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STUDIES AND REPORTS

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COMPULSORY SICKNESS INSURANCE

*Comparative Analysis of National
Laws and Statistics*

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PREFACE

In 1925 at its Seventh Session the International Labour Conference adopted a Resolution requesting the Office to continue its work of collecting information with regard to social insurance, and specifying that the information to be collected and published should relate not only to the progress of legislation but to the statistics of its working. This Resolution goes on to prescribe that the information furnished by the Office should, as far as possible, give in detail for each country and for each risk:

- (a) the classes and number of workers covered, i.e. whether independent workers, workers for salaries or wages and others, and also the occupations covered (distinguishing between compulsory and voluntary systems);
- (b) similarly the classes and numbers not covered by the systems;
- (c) the benefits
 - (i) nature, i.e. in kind or in cash,
 - (ii) amount,
 - (iii) duration,
 - (iv) conditions attached;
- (d) how the cost is borne
 - (i) by the State or other public authority,
 - (ii) by the employer,
 - (iii) by the persons covered;
- (e) the total annual cost under heads (d) (i, ii, and iii), with the proportion of the workers' and employers' contributions to the wages paid;
- (f) the precise methods of administration centrally and locally;
- (g) the expenditure annually
 - (i) on benefits,
 - (ii) on administration,and the numbers who receive each kind of benefit and the economic effects of the system as a whole in each country;

- (h) the use of social insurance reserves for the improvement of public health.

In submitting the Resolution to the Conference the Reporter of the Commission on General Problems of Social Insurance stated that the programme therein drawn up was evidently a maximum programme, and that the extent to which it could be carried out depended on the information which the Governments and organisation of employers and workers could supply to the International Labour Office.

This vast and detailed programme the Office has endeavoured to carry out in the present volume, which consists of six Parts devoted to the systematic examination on an international basis of the essential aspects of compulsory sickness insurance: scope; benefits; financial resources and their management; institutions and supervisory authorities; disputes, judicial authorities, offences and penalties; the situation of foreign workers.

In each Part, Chapter, or Subdivision the same method has been followed: in the first place the essential elements of the problem are set forth; then the characteristics of the different types of solution; next, a classification of the laws of the several countries according to the solutions which they embody; and lastly, an analysis of the national laws and the statistics of their working.

By the use of this method endeavour has been made on the one hand to give a general survey which enables the various systems to be understood in their relation to the movement of ideas and the evolution of social institutions, and, on the other hand, presents the law in each country in a form sufficiently exact for it to convey a correct impression of its character. In this work, therefore, one must look neither for a complete presentation of social doctrines nor for the integral reproduction of the laws and regulations of the several countries in all their details, but for a methodical summary of the plans which have been realised in legislation and an analysis of the essential character of the various national systems.

In presenting the statistical evidence of the working of the laws in the different countries, data relating to a series of years have been given wherever available. The idea has been to give the figures for the period commencing immediately before the war and continuing up to 1925. This, however, has not always been possible. For some countries, in spite of requests addressed to Governments and associations of employers or workers, no statistics are obtainable. For others, again, the information relates only to a

few years or even to a single year. Moreover, as the official reports of insurance institutions are published one, two, or even three years late, the tables often stop at 1924 or even 1923. The national statistics, the character of which is mainly determined by that of the laws to which they respectively relate, exhibit considerable differences. Though it cannot be claimed that they are comparable, an attempt has nevertheless been made to present them in a systematic manner by classifying them and calculating certain ratios with respect to those matters which possess the greatest international interest.

The importance of brevity has been borne in mind, although the size of the volume might appear to demonstrate the contrary. It would, perhaps, have been possible to attain a still greater degree of concision. In the first place, however, there was not time to present the matter in a more condensed form, and then it will no doubt be understood that it is no easy task to summarise 350 laws and regulations, 220 reports of various kinds (representing tens of thousands of pages of legal or technical works and thousands of statistical tables) written in some fifteen languages.

In the course of translation, classification, and abbreviation, some, perhaps many, errors have been made both in the interpretation of the laws and in the reproduction of statistics. As the International Labour Office is not likely to be able to undertake another international survey of sickness insurance for some years to come, the proofs of this study were distributed at the Conference with a request to representatives of Governments, employers, and workers to point out any important omissions or any errors which they might discover. Several, but unfortunately too few, responded, and their observations have been taken into account and utilised for the improvement of the study: sincere thanks are due to them for their aid, which enables the final edition to carry a greater guarantee of accuracy.

GENERAL INTRODUCTION

The nature, extent, and value of sickness insurance are closely related to the progress of industrialisation and of workers' and employers' organisations, and to the evolution of economic conceptions and of political and social forces. The aim of this Introduction is to outline briefly the important phases of the development of the institutions of compulsory sickness insurance and to indicate its present tendencies.

§ 1. — Historical Development of Sickness Insurance

THE GUILDS

Until the end of the eighteenth century industry consisted mainly of handicrafts. Journeymen and masters worked together in small workshops; both were organised in craft guilds which, thanks to the privileges and the practical monopoly which they possessed, were able to secure stable labour conditions. Often the workman lived in the family of his employer, where he was cared for in case of sickness. The need for insurance, which was thus less keenly felt, was sometimes met, at least in part, by relief funds established by the guilds.

THE EFFECT OF THE REVOLUTION AND THE INTRODUCTION OF LARGE-SCALE INDUSTRY

The revolution abolished the guilds, which had become tyrannical and an impediment to progress; it even forbade the creation of trade associations. It proclaimed the equality of all persons before the law and economic freedom. The relations between wage-earners and employers were henceforth governed by common law, and the individual worker was to settle freely with his individual employer the terms of the contract of employment. Such was

the essential character of the juridical system, forgetful of trade solidarity, in which the workers had to face the great industrial revolution that engendered the immense army of wage-earners.

A few years after the establishment of equality before the law, with which trade solidarity was inconsistent, large-scale industry began to develop.

The machine was substituted for the craftsman's hand labour; small workshops gave place to large factories, which attracted hundreds of thousands, and later on millions, of workers from the country. Thus there was concentrated into the towns an immense proletariat whose livelihood depended solely upon wages.

Large-scale industry, which developed continually, remained for a long time unorganised. It did not know how to estimate the capacity of consumption, and frequently suffered from crises and overproduction. This anarchy in production aggravated competition, rendered the labour market chronically unstable, and led to much unemployment, sweating, lowering of wages, and excessive lengthening of hours of work.

The worker in the big factory, badly paid, unable to save, weakened by exhausting labour and insufficient nourishment, fell into destitution when unable to work through sickness. This was a period of great misery, when there was slowly formed, under the pressure of suffering, the feeling of solidarity which was necessary for the achievement of security against the risks of the worker's life.

THE INDIFFERENCE OF THE "LAISSEZ-FAIRE" STATE

In face of this distress the *laissez faire* State preserved an attitude of indifference. Believing as it did in equality before the law and economic liberty, it elevated inactivity to the dignity of a doctrine. Statesmen and Members of Parliament were fully occupied with political problems; few indeed appreciated the social significance of the industrial revolution which was going forward under their eyes. Thus for a long time the public authorities intervened no further than to distribute bread tickets to the families of workers who were sick and unemployed.

Nevertheless, towards the middle of the nineteenth century, as industrialisation became more intense, the conviction grew that the community itself would suffer in its health, its productive

capacity, and its future by reason of the distress of its producers. It was then that the first laws for the protection of workers were planned, though they were in the nature of cautious experiments aiming merely at mitigating the sweating of women and children. So powerful still was the doctrine of *laissez faire* that special labour legislation was not to be thought of, nor could any responsibility be placed upon employers even for the compensation of industrial accidents, save in a few occupations where the risk is especially great (seamen and miners).

THE EFFORTS OF EMPLOYERS

In contrast to this passive and hesitating attitude of public authorities, private individuals took measures of a bolder character.

Employers, realising that distress breeds a dangerous temper, guided also by a feeling of social duty and desiring to secure the services of a labour force which should be stable, healthy, and loyal, began to organise schemes of welfare and relief. The third quarter of the nineteenth century witnessed the appearance of numerous employers' welfare institutions: hospitals, homes, and funds for pensions and relief.

The work of the employers, however, could not claim to solve the problem of the insecurity of wage-earners. Their schemes covered only a small proportion of the working class. Their basis of organisation, which is the factory, is generally too narrow to afford adequate cover against the more serious risks, such as industrial accidents, lengthy illness, invalidity, and old age. They suffer from too great variety of plan and from dispersal of effort. What is worse, they excited the distrust of the masses and the opposition of the Socialist Parties, which were rapidly growing up. The worker and his trade union saw in the employers' generosity a means of restricting the worker's freedom of movement and binding him by the ties of material interest, apparent rather than real however, to the undertaking which employs him. The Socialist Parties objected to the employers' schemes on the ground that their one-sided management excluded the workmen, that they offered none of the educative opportunities which are necessary in a democratic State, that it weakened the will of the working class to emancipate itself, and that after all the benefits offered were fragmentary and of little value.

THE EFFORTS OF THE WORKERS

The mind of the workers was gradually penetrated by the conception that they existed as a social class. They comprehended that equality before the law and political and economic liberty left them defenceless in the new industrial organisation. They discovered that in bargaining between individual worker and individual employer there is no genuine equality, and that in fact the terms are always imposed by the employer, who is always stronger because he is richer. They perceived that for one who depends for his livelihood upon wages there is no liberty without economic strength. Thus they came to regard their interests as distinct from those of their employers and especially as opposed to those of the owners of great undertakings. This class feeling led to the creation of class institutions. The latter took up with the public authorities a struggle to obtain the right to establish and administer defensive associations and funds for collective provision against risks to which all were exposed.

It is a fact that the forbidden trade union sometimes disguised itself behind a relief fund, which was first of all tolerated and then recognised; but more often it was the trade union which became the embryo of the provident fund. From Great Britain, the classic land of friendly societies, the mutual aid movement spread over to the Continent. At the outset mutual aid societies were based on trades, like the mediæval guilds. Whilst, however, a society's connection with the trade association, from which it sprang, secured for it the support of trade unionists, the range of its membership was at the same time restricted, and its financial resources were limited to the small contributions which the organised workers were able to pay. Its basis of organisation was not large enough to enable it to undertake insurance against the more serious risks of prolonged illness or disablement. Thus the mutual aid side of trade union activity had a precarious origin, and remained restricted both in its range of action and in its resources. Nevertheless, it supplied the foundation of a system which was later to be developed with the aid of the public authorities.

STATE INTERFERENCE AND THE DEVELOPMENT OF MUTUAL AID

The State was changing its attitude, and during the last thirty years of the nineteenth century took an increasingly active part

in the solution of problems of labour protection. This new development was due to a variety of causes. In the first place, the character of the legislators themselves was altering. Elected by universal suffrage, the Member of Parliament must henceforth pay careful heed to the needs of the working class, which had discovered in the voting paper a powerful weapon and which counted for much in the formation of public opinion. The workers' unions grew in number and strength; they began to group themselves into trade federations, which made energetic representations to parliaments and cabinets. The class sentiment was spread and fortified by the propagation of Socialist teaching. The doctrine of State interference acquired wide acceptance, so that old-fashioned *laissez faire* found itself hard pressed in the field of social and economic policy. The public authorities felt the influence of the unions and the new theories, and were also learning a lesson of experience. They recognised that absolute liberty in the conclusion of a labour contract and the prohibition of trade combination results in victory for the stronger party, who is the employer. The State no longer considered its task to be limited to authorising the establishment of schemes of welfare or mutual aid and to regulating the relations between the managers of such schemes and the beneficiaries, according to ordinary law. The State endeavours to encourage the mutual aid movement by giving it a special status, more favourable than that possessed by commercial associations. It goes further, and, recognising its responsibility for the protection of public health and for promoting national prosperity, it undertakes to give financial assistance to mutual aid societies.

Thus encouraged and supported by the public authorities, the mutual aid movement has greatly increased its scope in the course of the last half century. It has been able to create in many countries thousands, and even tens of thousands, of institutions with a membership which is counted in millions. Nevertheless, while admiration is due for the efforts and achievements of this splendid work of voluntary solidarity, one cannot consider it as an adequate solution of the problem of the insecurity of the working class.

The membership has remained at a low figure: after fifty years of effort, the friendly societies in many countries have only succeeded in bringing in a small proportion of the working class. Many workers fail to insure, some by improvidence and others through lack of means. In particular, those earning low wages do not join the societies: forced as they are to apply the greater

part or the whole of their earnings for the satisfaction of immediate needs, they are both less able to save and more frequently ill.

Again, the number of societies is excessive: tiny societies abound. Their small membership endangers their financial soundness and renders them unsuitable for undertaking insurance against prolonged sickness or invalidity. There is little order in their distribution about the country: in the cities they are to be found by hundreds, while in sparsely-populated rural districts they are sometimes altogether lacking. The scattered membership and divided effort result in gaps and overlapping, which weaken the social effectiveness of a nation's mutual aid system.

Moreover, friendly societies always suffer from narrowness of means. The contributions which members are willing to pay are rather low, and, even if they are supplemented by public subsidies, they do not allow the provision of benefits adequate to cover the risk.

THE DEVELOPMENT OF COMPULSORY SICKNESS INSURANCE

In spite of its valuable achievements, the voluntary insurance movement has been found insufficient, and it has become clear that the way to secure general and effective protection against the risk is by making insurance compulsory.

The modern State, as guardian of public health and national prosperity, considers it both a right and a duty to impose compulsion. Even the devotees of individualism admit that in a well-organised community a person should not be free to indulge in improvidence which leads to his becoming a charge on the rates, and that insurance is a social duty the performance of which the State may, in the general interest, enforce.

Germany in 1883, without making lengthy experiments with the voluntary method, was the first to make sickness insurance compulsory for industrial workers; shortly afterwards, in 1885, the scheme was extended to commerce and in 1886 to agriculture.

This creation of Bismarck's, so keenly opposed at first by the German working class, was doubtless inspired by a political motive. Its purpose was to attach the workers to the State as the defender of the capitalist system. It aimed at rendering innocuous the numerous relief funds connected with trade unions, which might have been dangerous weapons in a class struggle. By rendering secure the means of subsistence of the working class, his plan

raised a solid barrier against Socialist propaganda. It is for this reason that in the system of compulsory social insurance, introduced between 1883 and 1889, it is compulsory not only to insure but to belong to a specified fund. But whatever may have been the intentions of its originator, it is undeniable that the German scheme has exercised a great influence on the legislation of a large number of other countries.

The example of Germany was followed rather slowly by a few industrial States. Austria and Hungary in 1888 and 1891 introduced the system of compulsory sickness insurance applying to wage-earners in industry, transport, and commerce. At the beginning of the twentieth century, however, development became more rapid. Luxemburg in 1901, Norway in 1909, Serbia in 1910, Great Britain and Russia in 1911, and Roumania in 1912 all accepted the principle of compulsion. The Russian law is still the basis of the Esthonian and Latvian systems.

The movement of legislation, held up during the war, was resumed with fresh vigour on the conclusion of peace.

The European States created by the Peace Treaties have endeavoured to perfect the insurance schemes which they have inherited. Thus, Czechoslovakia in 1919, Poland in 1920, Austria in 1921, and the Serb-Croat-Slovene Kingdom in 1922 have made sickness insurance compulsory for all wage-earners. Bulgaria, which in 1918 had adopted the compulsory principle, applied it in 1924 to all classes of workers. Portugal in 1919 and Greece in 1922 likewise accepted the principle. Soviet Russia abandoned the system of public assistance established in 1918 for compulsory insurance, the plan of which was incorporated in the 1922 Labour Code when the new economic policy was inaugurated. Lithuania passed in 1925 a sickness insurance law, which, however, is not yet in force. Lastly, France, after four years of investigation, discussion, and controversy, is on the point of establishing a vast scheme of compulsory insurance against sickness, invalidity, old age, and death.

To States outside Europe industrialisation came later, and they have long maintained a waiting attitude with regard to compulsory insurance. Nevertheless they are beginning to recognise the effectiveness and necessity of compulsion. Thus, Japan in 1922 and Chile in 1924 have set up compulsory systems. The Governments of Australia and South Africa have appointed commissions to study schemes of compulsory social insurance, and Brazil is preparing a Labour Code which will include compulsory sickness insurance.

After forty years of experiment, uninterrupted effort, and success in all parts of the world, the cause of the compulsory principle seems now to be finally gained, and compulsory sickness insurance appears likely to occupy an increasingly important place in the social legislation of every country.

§ 2. — The Present Tendencies of Compulsory Sickness Insurance

SCOPE

As a rule, compulsory sickness insurance laws determine their scope mainly on the basis of the contract of employment: they are intended essentially to apply to the class of wage-earners, and it is only by way of exception that they make insurance compulsory for some small groups of non-wage-earners.

Nevertheless in the course of recent years some schemes have been established which abandon the basis of the employment contract, extend beyond the borders of the wage-earning class, and make insurance compulsory either for all workers or all persons of small means. This tendency towards popular insurance, however, has only manifested itself to a limited extent. Out of twenty-three countries where general schemes of compulsory sickness insurance are in operation, twenty have a scope restricted to wage-earners, and only three the popular system: Chile, Portugal, Switzerland (Cantons of Appenzell, Inner and Outer Rhodes, Basle Town, St. Gall, and Thurgau). Moreover, voluntary insurance for persons of small means working on their own account, which forms a complement to many compulsory schemes, has, with few exceptions, met with little success. It seems therefore that compulsory sickness insurance will long retain its character of working-class legislation.

The degree of development of workers' insurance is indeed very unequal from country to country: the proportion of insured persons varies from 3 to 35 per cent. of the total population and from 15 to 86 per cent. of the employed population. These wide differences are to be explained not only by the variable importance of the wage-earning class in the population of each country, but also by the operation of restrictions which in the different schemes limit the effect of the general formula of compulsory sickness insurance. These restrictions, however, are gradually being lessened or removed.

Applying at the outset to workers in certain industries only (mines, shipping) and then to industrial workers as a whole, the scope of compulsion now includes the wage-earners in industry and commerce in eighteen States, and restrictions, based on the size of undertakings and degree of risk, have, except in Japan and Esthonia, disappeared altogether.

The penetration of compulsory insurance among agricultural workers has been retarded by certain practical difficulties in administering benefits which arise out of the dispersion of the insured. Experience, however, has shown that these difficulties can be surmounted. Furthermore, the situation of agricultural workers is rapidly changing: they are organising in trade unions which are asserting their need for social legislation. The consequence has been the extension of compulsory insurance to agricultural workers in eleven States, ten of which have adopted the system in the last fifteen years.

The movement for the extension of scope embraces not only the great branches of economic activity, but also certain less important occupational groups such as domestic servants, who formerly were regarded as members of the family, so that they had less need for insurance, and home workers, the nature of whose labour contract is sometimes difficult to define.

Insurance institutions are rapidly acquiring great practical experience and are no longer held up by certain difficulties which arise in the case of persons who work for several employers. Now that the system of deducting the contribution from wages is becoming general, it is becoming more usual to extend the protection of insurance to temporary workers (the minimum duration of employment growing ever shorter) and to seasonal workers.

On the other hand, restrictions on the application of insurance to non-manual workers whose earnings exceed a certain maximum appear to find strong support in several countries: certain important schemes recently proposed would indeed prescribe such a limit for manual workers as well.

Nevertheless on the whole one may say that the general formula of compulsory insurance for wage-earners, without restrictions as to the nature of the occupation, undertaking, or as to the character and duration of the employment, is gaining increasing acceptance and that compulsory sickness insurance is aiming at covering the whole class of wage-earners or at least all such as are of small means.

BENEFITS

While the extensiveness of compulsory insurance is defined by its scope, the intensity of its effects depend on the nature of its benefits. The benefits which insurance undertakes to provide supply the proper index of its value: they correspond to the task assigned to sickness insurance in the entire effort which is being made to give the workers greater economic security and peace of mind.

It is perhaps possible to perceive among the benefit systems of the countries where insurance is compulsory certain common features which will indicate a tendency to evolve on convergent lines. One may enquire whether the final object of sickness insurance is the same in the several countries or whether on the contrary the differences as to the character and content of the benefits are attributable to dissimilarity of views as to the mission of insurance. The tendencies which may be referred to as characterising the development of national schemes after the war are perhaps sufficient to represent with some degree of certainty the direction which benefit systems are taking in the several countries.

One of these tendencies by itself would seem sufficient to give a new outlook to sickness insurance. Insurance should no longer confine its efforts to meeting the needs which arise from the weakness of the human constitution: it must pursue the evil to its origin and no longer accept sickness as a risk which cannot be averted. Insurance benefits must look to the source of disease and not merely to its consequences. Their final object is not assistance but the creation of new productive capacity.

Compensation for economic loss is henceforth only one of the functions of an insurance system designed to economise human energy. The principal object is to reduce as far as possible the damage resulting from avoidable disease and to provide healthy living conditions for the workers. Insurance would combat disease in its cause. If, however, an illness cannot be prevented, then the business of insurance is to compensate and restore to health. It can never indeed give up its original function of providing the sick with the means of subsistence to replace the earnings which cease with sickness; nevertheless, in order to eliminate the cause of such loss of earnings, it is the endeavour of insurance to cure the sick person and restore him to active life as soon as possible. With these great tasks of cure and prevention in mind, insurance

would naturally tend to complete and perfect its benefit system.

The adaptation of the benefit system to the requirements of insurance, which moreover are continually increasing, cannot be accomplished at a single stroke. The extension and improvement of benefits result from an evolution which proceeds slowly and by stages. The minimum benefits prescribed in the original law are in the first place exceeded by certain institutions operating under favourable conditions. Measures for supplementing the legal minimum are carried into effect, prove their value, and establish a new standard, towards which the less fortunate institutions will strive. The encouraging experiment which has been made leads to the legal recognition of the new development: a benefit hitherto optional now becomes compulsory for all insurance funds, the rate of benefit is increased, and the use of insurance resources for purposes of hygiene is henceforth accepted. The advance may be hardly perceptible, but, in view of the progress achieved here and there along the same lines, the result may be of importance. The transformation of the benefit system is a long-period operation; in order to measure it, one must consider together the different changes in detail introduced in benefit systems in order to strengthen one or other of its functions. Certain improvements affect not one function only, but several at once. The reader may judge for himself the principal improvements which have been adopted during the last few years in insurance benefits.

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Insurance proportions to the needs of the individual the subsistence allowance which it pays to sick persons incapable of work. It cannot, as has already been observed, renounce this, which was its original function but no longer its principal one. Two conceptions of the purpose of sickness benefit may be admitted. According to the one, the sick person is to be maintained at his standard of living and must therefore receive a benefit which is proportionate thereto. According to the other conception, however, a less important place is attributed to sickness benefit, which is intended to represent the strict minimum of existence during the period of inactivity. The variable benefit provides the sick person with assistance which meets his needs as determined by his standard of living: it has been universally adopted in continental Europe since before the war. It has, moreover, been preferred by

all the compulsory insurance laws which have been passed later, e.g. those of Chile, Japan, Poland, Russia, and the Serb-Croat-Slovene Kingdom.

The tendency to adapt the benefit to individual needs does not stop there. It shows itself likewise in the authorisation given to institutions in several countries to increase the rate of benefit in cases of prolonged illness, when the private resources of the patient have been exhausted. Moreover — and this is an aspect which represents very clearly the tendency of insurance to individualise its benefits—family responsibilities are in a growing number of countries taken into account in deciding the benefit rate. At present, the adjustment of benefit to family responsibilities is provided for in the German mining insurance law, and in the general insurance laws of Bulgaria, Chile, Esthonia, Lithuania, and Roumania. Further, family allowances to be added to the basic rate of benefit are optional in Austria, Czechoslovakia, France (Alsace-Lorraine), Germany, Great Britain, Latvia, Poland, and the Serb-Croat-Slovene Kingdom. Family allowances, which afford an index of the family character which sickness insurance is assuming, are a sign of the tendency to take account of the needs of the patient, which vary according to the number of his dependants.

Restoration rather than compensation is, however, the principal function of insurance. In its origin insurance aimed at providing the sick with benefits in kind to replace the wages which they were unable to earn. Little by little this idea has yielded to a wider and more genuinely social conception which makes the restoration of the patient the first consideration. Benefits in kind intended to restore the health of the patient begin to overtake cash benefits. Medical aid, which consisted hitherto of a rapid consultation with the insurance doctor, becomes more ample and improves. Drugs, which are an indispensable complement of medical treatment, are supplied at the cost of insurance. Hospital treatment may be substituted for consultation with or visits by a doctor, and becomes an ordinary benefit. In countries where medical aid is organised by insurance more or less collectively, the advice and attention of specialists are made available for insured persons. Such dental treatment as may be necessary is also generally provided by insurance. Special kinds of treatment, baths, and residence in convalescent homes enable the cure of insured persons to be completed under the same conditions as that of the rich.

The list of benefits in kind becomes longer and more complete;

the new additional benefits prescribed in recent laws consist almost exclusively in the grant of special treatment and in the supply of curative means. In the majority of schemes the expenditure on benefits in kind is as high as the cost of cash allowances, and has even exceeded it in several countries where special attention is given to the quality of medical aid.

Sickness insurance is taking on a family character: it protects the worker's family and no longer the insured person alone. Even the first compulsory insurance laws took care of the insured woman and her child: sickness funds were made responsible for assisting insured women during confinement and for providing them with allowances to cover expenditure arising on this occasion. Post-war legislation has increased maternity benefits: insured women are entitled to the care of a midwife and, in case of need, to medical attention, and receive allowances during the rest period which precedes and follows confinement. In many countries the mother is entitled to a nursing benefit and a contribution to the cost of the layette. Antenatal medical advice, reception in maternity homes and medical care of new-born children — all these bear witness to the interest which sickness insurance is taking in the welfare of mother and child. In all countries having a sufficiently developed system of compulsory sickness insurance, the latter performs the functions of maternity insurance as well.

The efforts of insurance do not stop there, however; mindful of the social importance of protecting maternity in the working class, it does not restrict itself to assisting insured women during confinement. In a large number of countries it provides benefits for the wives and other dependants of insured persons in case of confinement. Out of 23 compulsory insurance laws 14 provide maternity benefit for the wives of insured persons.

Sickness insurance, however, goes yet further in caring for the working-class family, which is provided with a medical and drug service in the same way as the insured person himself. The movement to provide medical aid for the insured person's family, which was visible before the war only in a few States, has become much stronger in recent years. The ravages of the war have rendered more necessary than ever the organisation of medical aid for the masses of the population. A large number of sickness insurance schemes in spite of financial obstacles have granted the right to medical aid to the insured person's family: family medical aid forms in Czechoslovakia, Hungary, Latvia, Norway, Poland, Roumania, and the Serb-Croat-Slovene Kingdom one of the ordinary elements

of the benefit scheme and by these means medical care is made available to the majority of the working class. Assistance of this kind is likewise rendered compulsory in the new Austrian, Lithuanian, and Portuguese laws. In other countries, and especially in Germany and Luxemburg, insurance institutions have taken advantage on a large scale of the option to provide medical aid for the worker's family. Thus tens of millions of workers' households in the various countries of the European continent are entitled to free medical treatment. Sickness insurance has become the guardian of the health of the workers' family. In virtue of this task, which it has taken up widely of late years, sickness insurance has become the principal instrument of a health policy for the masses of the population.

Insurance is interested in the prevention of sickness. It realises that it is better to prevent than to cure and that a vigilant preventive policy can avoid the loss of productive capacity, render available the resources which are used up by avoidable disease, and increase the material, intellectual, and moral well-being of the community.

Already the protection which insurance gives to maternity is a sign of the desire of insurance to see that the confinement and the subsequent care of the mother and infant should be carried out and arranged for so as to secure satisfactory conditions of hygiene. The extension of maternity benefit to the dependants of the insured person, which is provided by all laws drafted in the last few years, is evidence of the concern of insurance in prophylaxis. The supervision of the birth and nursing of the worker's child by insurance represents a preventive measure of the greatest importance for the next generation. Moreover, medical aid for the insured person's family, the rapid development of which has already been noted, is also a most effective element of a preventive policy. The extension of medical aid to the insured person's family is in itself a preventive measure in the most real sense of the word because it makes the doctor's services available to the masses of the population, which thereby for the first time are placed under medical supervision and given the right to call in a doctor's aid in good time.

Insurance, however, is creating for itself other means of preventive activity to which later on legislation gives its approval. The insurance institution gives preventive care to as large a number of persons as possible as soon as the symptoms of disease appear. Besides the protection of individuals threatened by, or having a

predisposition to, disease, there is the general preventive policy and the campaign against social diseases and for raising the standard of the health of the masses of the population. Insurance takes its part in this campaign, and is especially energetic in countries where its territorial organisation facilitates an action which, because it is concentrated, is efficacious.

Insurance organises the administration of benefits. It abandons the primitive policy of leaving to the beneficiary the responsibility of choosing the means to satisfy his requirements. The insured person receives a sum of money and exchanges it for the goods and services which he needs: he disposes of the benefit as he likes and enjoys in this respect great liberty, but he takes the risk of the benefit being insufficient to meet his requirements. Insurance, however, no longer seeks to discharge its responsibility by a mere allowance and the repayment of medical expenses to the patient. It endeavours to alleviate his physiological and economic needs by placing at his disposal the goods and services which he requires. The patient is provided with medical advice and drugs, and is maintained at the expense of insurance in a hospital or convalescent home.

Insurance institutions are obliged to organise the service of the benefits for which they are responsible. They have recourse to the medical equipment (hospitals, etc.) of the country, and make arrangements for the provision of medical treatment, the supply of drugs, and hospital accommodation on behalf of the insured. The general medical equipment of a country, however, may be inadequate for the requirements of insurance, or may not be available under equitable conditions. The insurance institutions then set about completing the equipment which they need to achieve satisfactorily the cure of the sick. They make themselves responsible for the management of such establishments as dispensaries, treatment centres, maternity homes, ~~convalescent homes~~, and create for themselves their own medical equipment. In this way, especially in countries of Central Europe; namely, Austria, Czechoslovakia, Germany, Hungary, Latvia, and Poland, the sickness funds, with the object of systematising the provision of benefits in kind are completing and enriching the general medical equipment of the country.

THE SHARING OF THE COST

The operation of sickness insurance absorbs a certain fraction of the national revenue, and the law which makes insurance

compulsory must determine what groups of the community are to share in the cost, and in what proportions. This twofold problem is much more difficult to solve than the corresponding problem in workmen's compensation.

The risk of industrial accident is unquestionably a trade risk. An employer who sets in motion certain activities and brings together workers and machinery creates an organisation the working of which may cause, and does in fact cause, injuries irrespective of any idea of fault on his part. The pecuniary loss resulting from industrial accidents and diseases is one of the liabilities of the undertaking, just like repairs, depreciation, or wages. The cost of accidents, therefore, is included in the overhead charges, and must be born by the employer. Such is the principle of trade risk which is nowadays admitted almost everywhere.

The idea of responsibility, which plays so important a part in industrial accident insurance, does not afford a sufficient basis for the sharing of cost in the case of sickness insurance. Sickness may result from causes peculiar to the individual or to his occupation, or to what may be termed social causes, and accordingly the responsibility involved may be that of the insured person, the employer, or the public authorities. It is, however, hardly possible to appreciate the share of responsibility for each individual or each group. Moreover, cases of sickness which are purely fortuitous, and imply no responsibility, are very numerous.

In the absence of a juridical principle based on responsibility for the occurrence of the event insured against, regard is had to the value which insurance may offer to the insured person, the employer, or the State. The interest of the insured person as the recipient of benefits is evident. That of the employer who needs a healthy and stable labour force is likewise incontestable. That of the State, which is responsible for public health, is not less evident. Even so, there remains the insuperable difficulty of calculating the value of sickness insurance for any particular individual or group.

In practice the money necessary to work sickness insurance is provided by insured persons, employers, and public authorities.

The principle of the workers' contribution has been accepted in all countries except Soviet Russia. The question whether insurance should be contributory or non-contributory had almost ceased to be discussed — at least so far as sickness insurance is concerned. In the eyes of the workers and of the public in general the contribution is the feature which distinguishes insurance from

relief, creates a right to benefits, and justifies the participation of insured persons in the management of insurance institutions.

The principle of the employers' contribution is likewise accepted in all countries except Roumania — and even there a plan is on foot to introduce it — and in five Swiss Cantons where insurance is compulsory: Appenzell (Inner and Outer Rhodes), Basle Town, St. Gall, and Thurgau, where the scope of insurance includes non-wage-earners.

On the other hand, a contribution from the State to the cost of insurance is less usual than a contribution from workers and employers. The State contribution is still a subject of controversy, and there are still many social thinkers who consider that the upkeep and depreciation of "human capital" should represent a normal element in the cost of production. They regard insurance contributions as a fraction of wages reserved by an institution collectively managed and paid out, not to all the individuals who have contributed, but to those for whom the need arises when they fall sick. These thinkers conclude that the State is not called upon to aid in the finances of insurance.

The State, which is responsible for the organisation of public health for the population as a whole, finds a powerful aid in the insurance funds, which devote immense sums to the provision of a medical service and the creation of medical equipment, which, moreover, are taking an increasingly active part in the sphere of sickness prevention, and which are conferring ever more important benefits on the dependants of insured persons. Does not such action go beyond the duties which may be legitimately imposed directly on production, and does it not call for aid of a material character from the whole national community :

Either of these two ideas may predominate according to the country, and at the present time a contribution from the State is found in about half of the compulsory sickness insurance schemes in operation.

The impossibility of measuring exactly either the share of responsibility in the occurrence of the event insured against, or the advantages which any party obtains from sickness insurance, explains the variety of solutions which have been given to the problem of the distribution of cost.

The contribution of the insured person is very rarely less than, and is almost always equal to or greater than, half the total contribution. It is often as much as two-thirds of the total contribution.

The contribution of employers is generally less than that of the

insured: it is usually fixed at a third or a half of the total contribution, and only rarely exceeds the latter proportion. The State's contribution varies widely both in character and amount. It may take the form of a fraction of the total contribution, a subsidy for each person insured, a share in the total cost of all benefits, or frequently of certain benefits only, maternity and nursing benefits, or benefits in the nature of family allowances.

The fact is that the basis for the sharing of cost is the result of a complex of conditions which varies from country to country, and even in the same country at different periods: the level of wages in relation to the cost of living (i.e. the ability of insured persons to contribute), the prosperity of production (i.e. the ability of undertakings to bear social charges), the state of the public finances (i.e. the possibility of obtaining from the taxpayer money to subsidise insurance), the power of trade unions of employers and workers, the composition, tendencies, and attitude on social questions of Governments and parliamentary majorities.

The solution adopted in each country is a compromise between the various conceptions and opposing interests and forces in which present considerations of expediency play a more important part than theories.

It is to be observed that the sharing of cost as fixed by the law undergoes modifications which may be very considerable through the very complicated working of incidence.

The worker who is obliged by law to pay a contribution will, especially if his remuneration is hardly sufficient to cover his daily needs, demand an increase of wages. The success of his demand will depend on the supply of labour, the strength of trade union organisation, the prosperity of the undertaking, and so on. Hence, the proportion of the contribution finally deducted from wages will vary widely.

The employer will tend to include his share of the contribution, and even all or part of the worker's contribution, in the cost of production, and transfer the burden to the consumer. Whether he can succeed or not depends on the situation of his undertaking or the industry, the purchasing power of consumers, conditions of national and international competition, tariffs, and so on, and the result will vary considerably from one undertaking to another. The State's contribution, which is paid out of national taxation, will be shared in proportions which depend on the system of taxation, and in the last resort will be borne either by the consumer, by wages, or by profits in widely varying proportions.

In view of the multiplicity of the methods adopted in the different laws, and of the incessant shifting of the initial incidence of the cost, it would be difficult indeed to express the actual process in a few simple formulae. Nevertheless, it may be observed that the principle of the workers' and employers' contributions is firmly established, and one may predict that insured persons and employers will continue to bear the greater part of the cost of sickness insurance. Lastly, one may expect that financial aid from the public authorities will find growing justification in proportion as insurance institutions extend their activity in the sphere of public health, the prevention of social diseases, and the protection of the health of the family and the race, which are matters which in every country are of interest to the nation as a whole.

INSURANCE INSTITUTIONS

It is in the methods and management of its institutions that sickness insurance exhibits most clearly its national characteristics. One may enquire how the Governments of the different countries make their choice among the different types of institutions: friendly societies, trade funds, works funds, and territorial funds.

Doubtless they are influenced by the advice of specialists, who are generally of opinion that the edifice of social insurance should be constructed or reconstructed on a scientific basis capable of giving the maximum result for a minimum of expense, and that consequently a system of territorial funds should be created to manage sickness, invalidity, old-age, and survivors' insurance. On the other hand, however, pressure is brought to bear upon the Governments by existing insurance institutions, which naturally do not desire to disappear, and, at the time when the laws are being voted, display an intense activity in order to defend their existence and obtain a place in the compulsory insurance scheme. To start with entirely new institutions would be dangerous, because it would arouse dangerous opposition against the compulsory principle, and so it is usual to arrange a compromise, in which the part played by the different types of institution varies with the number and power of the already existing voluntary insurance funds, the features of the public administrative system, the parliamentary majority, and the conditions of each country.

When the existing voluntary funds, whether friendly societies or trade associations, are sufficiently strong and numerous, the

law which makes insurance compulsory may simply authorise them to act as insurers, and refrain from creating new institutions.

This case is rather rare. In spite of its vigorous activity, the friendly societies, employers, and trade unions have not often succeeded, especially in rural districts, in building up a sufficiently close network of funds in all parts of a country. It is therefore necessary to set up new funds for those persons whom voluntary insurance has been unable to reach.

The compromise between a desire to systematise and an anxiety to safeguard existing funds results, in many countries, in a complicated and often incoherent congeries of institutions of different types, among which insured persons are distributed in widely varying proportions.

Thus, in Great Britain, where the management of insurance is entrusted to existing institutions, 46.5 per cent. of insured persons belong to friendly societies, 42.8 per cent. to industrial assurance approved societies, 9.9 per cent. to trade unions, and 0.8 per cent. to employers' provident funds.

On the other hand, territorial funds, which do not exist in Great Britain, play an important part in Germany, while friendly societies are hardly developed: 71 per cent. of insured persons belong to territorial funds (local or rural), 24 per cent. to trade funds (works funds, guild funds, and mining funds), and only 5 per cent. to mutual aid societies, known as substitute funds.

If one studies the movement of the membership of the different types of institutions in the course of the last fifteen years, one finds that in the majority of European countries the territorial funds have developed continuously and that trade funds, and especially friendly societies, have remained stationary, or have even lost ground.

This clearly marked preference for the grouping of all the insured persons in a particular area in a single institution is explained by the numerous and important advantages which this arrangement offers. In a territorial fund, in which all kinds of trades are represented, the good and bad risks compensate one another. The membership is stable, and is much less influenced by economic disturbances and unemployment crises, which might threaten the very existence of trade funds.

The territorial fund is particularly suitable for the organisation of medical benefits. It facilitates the unification of the various branches of insurance. Unification renders administration simpler and less costly, and enables the means of action to be concentrated,

so that medical equipment may be provided for each area, and may be used in common by both sickness insurance and invalidity insurance. These considerations predominate in States which, like Bulgaria, Czechoslovakia, Soviet Russia, and the Serb-Croat-Slovene Kingdom, have aimed at co-ordinating the whole of their insurance institutions.

Whatever has been the basis of organisation adopted, the management of insurance is always entrusted either to a State service or to autonomous institutions administered by insured persons alone, by insured persons and employers, or by insured persons, employers, and representatives of the public authorities.

State management is rare : it exists only in Bulgaria and to some extent in Japan (insurance offices). Even in these two countries, State management may perhaps be regarded as only a temporary feature, intended to prepare the way for management by the parties concerned when the development of trade unions of workers and employers and the progress in the social education of the mass of the population shall have made it possible for them to assume the task.

Autonomous management by the parties concerned is the plan which has received almost universal favour; it seems to fulfil the conditions required for efficiency and to respond to the wishes of insured persons and employers. The system of autonomous institutions, working under the supervision of the State, is one which makes it possible at the same time to apply uniform legal provisions and to allow the free play of initiative in the adaptation of the activities of institutions to special local needs.

Participation in management is, in the eyes of employers and even more of insured persons, a necessary corollary to the payment of the contributions which is imposed upon them by law. It interests insured persons in the good management of insurance, increases their feeling of responsibility, enables abuses to be prevented by mutual supervision, gives to workers a sense of sharing in a collective effort, and in this capacity serves as a valuable agent for the education of the masses of the population in democracy.

To decide what share of influence shall be given to each party is no easy task, and the plan adopted varies according to the type of fund and from country to country. Friendly societies set up by the workers themselves are of course managed exclusively by their members. In territorial funds and even in trade funds, insured persons are generally more strongly represented than

employers. The number of seats attributed to them, hardly ever less than half, is frequently as much as two-thirds of the total number, and sometimes even exceeds this proportion. A study of the movement of recent legislation reveals a well-marked tendency to increase the influence of insured persons in the management of insurance funds.

It may be concluded that the growing predominance of autonomous territorial funds administered by the parties concerned, and the attribution of an increasingly important share in the administration to the insured persons, are two of the most salient features in the evolution of the institutions of compulsory sickness insurance.

* * *

From this survey of tendencies, in spite of its deficiencies and brevity, it seems possible to reach the following conclusion. Sickness insurance is endeavouring to fulfil ever more completely its task of protecting the health of the working-class family and maintaining the workers' capacity to produce, by widening the circle of insured persons, perfecting the system of benefits which perform the threefold function of relief, cure and prevention, concentrating the means of action, and systematically organising autonomous institutions under the control of the parties concerned.

Thus, compulsory sickness insurance, as creator of security, health, well-being, and productive capacity, and as instrument of education, is an element both important and necessary in the proper economic and social organisation of communities.

PART I

SCOPE

PART I

SCOPE

INTRODUCTION

All persons are exposed to the risk of sickness, and its occurrence entails for them or their dependants either an increase of expenditure (cost of medical treatment and drugs) or a reduction, or even cessation, of income resulting from incapacity for work, or at the same time both an increase of expenditure and the cessation of income.

Sickness insurance, which has for its object the mitigation of the economic consequences of sickness, might therefore be organised in such a way as to insure the entire population against the increase of expenditure and the whole working population against the increase of expenditure and the cessation or reduction of earnings. At the present time the scope of compulsory social insurance against sickness is much less ample than that just indicated. It has been considered unnecessary to impose compulsion to insure upon persons who possess sufficient means to enable them to make their own arrangements for insurance, and, as the practice of voluntary insurance is widely developed among the richer classes, the extension of compulsion to millions of persons simply because among them there is a thriftless minority has been avoided in all countries.

The legal obligation to insure is therefore only imposed upon individuals whose means are presumed to be insufficient to enable them to carry the risk of sickness without the aid of the community. The cost of sickness is particularly heavy for the working class, who, in case of sickness, lose their earnings or wages at the very time when they have to meet expenses which may sometimes be very high. It is evident, however, that one cannot consider as

being of insufficient means all workers without distinction. Some persons working on their own account obtain high incomes and possess considerable independent means, while some persons in employment are in receipt of high salaries; it may be agreed that the latter, and still more the former, are able by themselves to make their own provision against sickness.

Moreover, the economic consequences of sickness may differ widely according as the worker concerned is a wage-earner or is in business on his own account. The wage-earner nearly always depends wholly or mainly for his subsistence upon payment for his work; when incapacitated by sickness, he loses the whole or the greater part of his income. The situation of the person working on his own account, however, is often better; for the shopkeeper, with the aid of his family, assistants, or servants, may continue to carry on his business at least to some extent, and to draw a profit from it.

The scope of national legislation has been determined so as to take account, on the one hand, of the great variety of the economic situation of workers and of their need for insurance, and, on the other hand, of the differences in the consequences of sickness for wage-earners and persons working on their own account respectively.

At the present time the majority of compulsory insurance laws apply solely or mainly to the social class of wage-earners, and only include a few relatively small groups of persons working on their own account.

Nevertheless, several recent laws have definitely gone beyond the limits of the wage-earning class, and have taken as the essential criterion for the determination of their scope the annual income of the individual. Thus they have made insurance compulsory for workers or for all persons of small means (popular insurance).

The subject of the first Chapter will be insurance schemes applying to wage-earners, and that of the second, insurance schemes intended for workers of small means and schemes of popular insurance. A third Chapter will be devoted to the operation of the compulsory principle, or, in other words, the process whereby a person actually becomes insured.

CHAPTER I

COMPULSORY INSURANCE OF WAGE-EARNERS

§ 1. — General Formula Defining Scope

Workers' insurance legislation as a rule makes insurance compulsory only for wage-earners, and, in order to define its scope, it should at the outset prescribe an exact definition of the term "wage-earner". Such, however, is not the case, doubtless because those responsible for the laws considered that the notion of "wage-earner" was in practice sufficiently clear, and that it would be better to leave to the courts the task of deciding doubtful cases. Although laws rarely contain complete definitions of wage-earning work, yet a study of their texts makes it possible to affirm that in order to be liable to insurance a person must be engaged in:

- (1) Work in a dependent position;
- (2) Work under a contract;
- (3) Work as the ordinary means of livelihood.

WORK IN A DEPENDENT POSITION

The wage-earner places his services at the disposal of one or more employers, whose instructions he must carry out. The employment must be effective, that is to say, the employer must be able to avail himself of the services of the worker, and insurance begins, not at the date when the labour contract is concluded, but at the moment when the worker presents himself for service. Once the worker is at the orders of the employer, it is of course not required that the work should be uninterrupted: insurance continues until the contract comes to an end or is broken.

The dependent character of the work is clearly marked in the case of the factory wage-earner: it is less apparent when the work is carried out at home on behalf of an undertaking, with materials

supplied by the employer, but not under his direct supervision. Separate consideration is given below to the position of home workers under compulsory insurance.

WORK UNDER A CONTRACT

The fact of performing a service for another person is not sufficient to entail liability to insurance: it is necessary that there should be a contract, which may be either written or oral, expressed or implied. By the terms of the contract the worker agrees to place himself at the orders of the employer, who for his part promises to remunerate him. Liability to insurance arises not at the conclusion of the contract, but at the commencement of its execution. As a rule, therefore, insurance only covers workers who receive remuneration from their employer. The application of this rule to unpaid apprentices, however, is subject to modifications, which receive special mention below.

WORK AS THE ORDINARY MEANS OF LIVELIHOOD

In general the scope of insurance includes persons who ordinarily derive their means of livelihood from wage-earning work. Although insurance laws do not prescribe a minimum rate of wages, they disregard occupations from which a worker derives only an insignificant part of the means necessary for his subsistence, whether by reason of the shortness of the employment or because they are subsidiary to his principal employment. A special section is assigned to the study of the policy of compulsory insurance laws towards occasional and temporary workers and to subsidiary employment.

The general formula is far from being strictly applied. Insurance is not always made compulsory for all branches of economic activity. Frequently the laws contain restrictive provisions relating to the character and duration of the work and to the physiological, political and economic situation of individual workers. Sometimes also the limits of the formula are exceeded, and non-wage-earners are brought within the scope of compulsory insurance.

In the following sections, therefore, will be studied the application of compulsory insurance to the different branches of economic activity, the restrictions arising out of the character and duration

of employment, the physiological, political and economic conditions required to be fulfilled by wage-earners, and the insurance of non-wage-earners. The voluntary insurance provisions which are often included in compulsory insurance laws, and the question of territoriality in insurance legislation, are treated in subsequent sections. At the end are inserted the national laws, summarised with a precision which could not be attained in the course of a comparative study, together with statistics for each country concerning the number of insured persons and their distribution according to occupation, age, sex, etc.

§ 2. — Application of Insurance to the Several Branches of Economic Activity

The extent to which compulsory sickness insurance has been applied varies from one branch of economic activity to another. Insurance was usually first established for certain specially dangerous occupations (miners and seamen) which entail the concentration of large numbers of workers and for which powerful trade unions of long standing have been organised. The severity of the risk, the high degree of corporate feeling and the prosperity of the undertakings have favoured the creation of trade funds for these occupations. Later, insurance was made compulsory for workers in industry and commerce, and finally for those engaged in agriculture, the tendency being therefore to include the whole body of wage-earners.

INDUSTRY AND COMMERCE

It is in the two branches of economic activity which employ the greatest number of wage-earners, namely, industry and commerce, that compulsory insurance has most securely established itself. The list of the first laws in each country which have made insurance compulsory for industrial and commercial wage-earners is already a long one:

Germany	1883-1885	Irish Free State	1911
Austria	1888	Roumania (industry only)	1912
Czechoslovakia	1888	Bulgaria	1918
Hungary	1891	Poland	1920
Luxemburg	1901	Esthonia (industry only)	1922
Norway	1909	Japan (industry only)	1922
Serb-Croat-Slovene Kingdom	1910	Latvia	1922
Great Britain		Russia	1912, 1917, and 1922
and Northern Ireland	1911	Greece	1923
		Lithuania	1925

In certain countries compulsory sickness insurance has only been instituted for certain occupations: for miners and seamen in France, and for seamen in Belgium.

It may be said very broadly that insurance legislation makes no distinction between industrial undertakings. Nevertheless, in two countries, Esthonia and Japan, the scope of the laws is restricted by conditions relating to the size of the undertakings and the degree of risk which it represents.

In Esthonia only those wage-earners who are employed in undertakings where there are at least five workers are subject to insurance.

In Japan, insurance is compulsory for workers in all mines and in factories where at least ten workers are employed as well as factories where the work is unhealthy or dangerous, even if less than ten workers are employed. On the other hand, employment in factories where the work is considered as healthy and without risk does not entail a liability to insurance, even if such factories employ more than ten workers.

The exception of small factories and undertakings where the work offers little danger is common enough in workmen's compensation laws. These restrictions, however, which clearly conflict with the principle of occupational risk, may be explained by a desire to simplify the working of insurance by omitting undertakings where accidents are rare. This consideration has evidently prevailed in Esthonia and Japan, being reinforced by the fact that sickness insurance and workmen's compensation constitute a single system. It is none the less true, however, that sickness is just as prevalent among the staff of small as of large undertakings, and may occur to workers in the healthiest occupations.

Persons employed in commercial undertakings enjoy the protection of compulsory insurance on the same footing as industrial workers, except in Japan, Esthonia, and Roumania. The gaps in the scope of sickness insurance are therefore few and of little importance in industry and commerce. Because the risk of sickness is universal, a constant tendency exists to expand the circle of persons insured, so that the few remaining restrictions will doubtless be removed sooner or later.

TRANSPORT (SEAMEN AND RAILWAYMEN)

Seamen are in all countries protected in the first place by the provisions of maritime and commercial codes which impose upon

shipowners the duty of caring for their crew when sick on board until they are cured or return to their country. In case of sickness which is prolonged beyond the period for which the shipowner is liable, sickness insurance becomes necessary. Seamen are comprised within the general scheme of compulsory insurance in Germany, Great Britain and Northern Ireland, the Irish Free State, Russia, and the Serb-Croat-Slovene Kingdom, while in France and Belgium they are protected by special schemes.

Railways are generally large undertakings, providing stable employment for thousands of workers. In many countries they belong to the State and their staff or certain grades may be treated as civil servants. But whether owned by the State or not railways usually pay part or the whole of the wages of some or all grades of their staff during even lengthy periods of absence occasioned by sickness.

The situation of railway workers in relation to compulsory insurance differs in the various countries. They may all be covered by the general scheme as in Lithuania, Norway and Russia. The clerical staff may be excepted from liability to insure on the express condition that they are entitled to benefits equivalent to those offered by the general scheme, and the manual workers insured under the general scheme: such is the case for example in Germany and Great Britain. Again, as in Esthonia, the entire staff may be excepted from the general scheme but granted, as civil servants, sickness pay and medical aid free of charge.

AGRICULTURE

Agriculture has been penetrated less rapidly by compulsory sickness insurance than industry or commerce. For a long time insurance seemed less necessary by reason of the patriarchal character of the relations existing between the employer and the worker in agriculture. It seemed more difficult to organise on account of the sparseness of the agricultural population. It may be also that insurance was called for less energetically by the trade unions of agricultural workers, which were in their infancy and often weak, especially in countries where small proprietorship is prevalent. Within the last thirty years, however, the situation of agricultural wage-earners has altered rapidly: the relations between employer and worker are losing their family character; trade union organisation is growing stronger; the need for social

protection is becoming clearer; and insurance, as it brings about an improvement in living conditions, offers a means of retaining on the land a labour force which is being reduced by the attraction of industrial centres.

Hence, the compulsory sickness insurance laws which cover agricultural workers are becoming more and more numerous. The countries which already possess a long established insurance scheme are extending it to agricultural workers, and the majority of countries which are setting up new schemes no longer make any distinction between land workers and factory workers. This tendency is already visible in the list given below of the many countries where the agricultural workers are liable to compulsory insurance; the date is that of the law under which such workers first became insured:

Germany	1886 and 1911	Poland	1920
Great Britain		Austria	1921
and Northern Ireland .	1911	Russia	1922
Irish Free State	1911	Serb-Croat-Slovene King-	
Norway	1915	dom	1922
Czechoslovakia	1919	Bulgaria	1924

Some reservations, however, must be made in conjunction with this table. In Poland compulsory insurance for agricultural workers has only been carried into effect in the former Prussian territory, and will only come into operation in the remainder of the country in the course of a transitional period which is due to end in 1936. Similarly in the Serb-Croat-Slovene Kingdom agricultural workers are provisionally omitted from the scope of insurance, pending the setting up of a special scheme on their behalf.

In Austria the sickness insurance of agricultural workers is a matter which belonged for some years to the competence of the provincial authorities; at the present time eight provinces out of nine have instituted compulsory insurance. It is probable, however, that in the near future a Federal law applicable to the entire territory will be adopted. In Russia the Code of 1922 prescribed that insurance should be compulsory for all wage-earners. Nevertheless, agricultural workers, except in State undertakings, were not covered until 1924.

In several States where insurance is compulsory for industrial and commercial wage-earners, agricultural workers are still unprotected. Such is the case in Esthonia, Greece, Hungary, Japan, Latvia, Lithuania, Luxemburg, and Roumania.

DOMESTIC SERVICE

Domestic servants living under the same roof as the employer worked for a long time under conditions of a special character, and sometimes they continue to do so. The relations between the employer and his servants have been influenced by family law. The little liberty granted to domestic servants, the quantity and character of whose work is not agreed in advance, has been to a certain extent compensated for by the duty which is imposed upon the employer of caring for them in case of sickness. The insertion of provisions conferring protection of this sort in a certain number of civil codes, e.g. that of Germany, has rendered the need of domestic servants for insurance less urgent.

As relations between the employers and servants have gradually ceased to be governed by family law and have assumed the character of labour contracts, it has become necessary to guarantee to domestic servants more regular and more precisely determined protection. It has been found that the care ordinarily given in the employer's family is insufficient, and it has no longer been possible to refuse to domestic servants the benefits of compulsory insurance.

Hence a large number of general workers' insurance schemes have included in their scope domestic and also farm servants. Such is the case in Austria, Bulgaria, Czechoslovakia, Germany, Great Britain and Northern Ireland, Hungary, Irish Free State, Latvia, Lithuania, Norway, Poland, Russia, and the Serb-Croat-Slovene Kingdom. Nevertheless, the laws of some of these countries allow exceptions on behalf of farm servants who, in Austria and the Serb-Croat-Slovene Kingdom, are not liable to insurance.

In other countries domestic servants remain excluded from the scope of compulsory sickness insurance. Nevertheless, in Luxemburg a domestic servant, should he be employed half-time in the industrial or commercial undertaking of his employer, becomes liable to insurance.

PUBLIC SERVICE

Employment as a permanent official generally implies, as a condition of service, the continuance of remuneration for a certain period during incapacity for work occasioned by sickness. With the realisation that from the point of view of public health pecuniary benefit alone was ineffective, and with the growing importance

attached to medical benefit, the public official was found to be in a less satisfactory position.

The problem to be solved was that of enabling officials to profit by the medical benefit of sickness insurance. Two alternative solutions have been found for this problem. The simpler of the two merely brings public officials into the general insurance scheme under the same conditions as other wage-earners. The second solution is to institute on their behalf a special scheme of insurance providing medical benefit only. Neither of these plans has as yet been adopted in the majority of countries. The commonest practice is to exclude public officials on condition that their treatment in case of sickness is equivalent to that afforded to persons insured under the general scheme. Equivalent treatment, however, does not usually imply that medical attendance is provided.

Insurance under the General Scheme

In two countries, namely: Norway and Russia, public officials and workers in State undertakings are assimilated to wage-earners for the purpose of insurance, and come within the scope of the general scheme; in this way, therefore, they become entitled to medical benefit

Special Scheme Providing Medical Aid

Special schemes for providing public officials with medical treatment have been instituted in Austria, Czechoslovakia, Esthonia, Hungary, Poland, and the Serb-Croat-Slovene Kingdom.

In Austria officials and employees of the Federal Government are excluded from the general scheme if they are entitled to not less than six months' sick pay. By the Act of 13 July 1920, however, a special insurance scheme was established under which these persons became entitled to benefits in kind at least as favourable as the corresponding benefits conferred under the general scheme. Moreover, this special scheme is also open under certain conditions to public authorities, which may cause their staff to be insured thereunder instead of under the general scheme. Similarly, in Hungary, civil servants paid by the State, who are also excluded from the general scheme, are insured together with their dependants in a medical aid fund.

The Polish general scheme applies to workers employed in undertakings and offices under the State or local authorities, except State civil servants nominated to appointments and not engaged

under a contract of work. The latter, in virtue of an Act of 1923, are given the right to free medical treatment, and the same privilege is extended to their dependants. The plan adopted in the Serb-Croat-Slovene Kingdom is practically identical: public officials, whether under the State or a local authority, who are nominated to appointments and receive their pay for at least 26 weeks during sickness are excluded from insurance, but are entitled to medical attendance and likewise to maternity and funeral benefits, and so also are their families; other persons employed in any capacity by the State or local authorities are insured under the general scheme. In Esthonia the benefits of sick pay, maternity and funeral benefits and medical aid for the worker and his dependants are provided gratuitously for all civil servants and manual workers in State institutions and undertakings.

In Czechoslovakia the Act of 15 October 1925 has established a medical aid fund on behalf of public service workers, membership being compulsory for civil servants and salaried workers employed by the State, State undertakings, public funds managed by the State, teachers, salaried workers employed by provinces, communes and other local authorities and by their undertakings, and for pensioners who have retired from the public services.

Equivalent Treatment

The exclusion of persons engaged in the public services on the ground of equivalent treatment is the policy which is still maintained in the majority of compulsory sickness insurance laws. If, however, the condition of equivalence is not fulfilled, liability to insurance under the general scheme comes into operation. The countries concerned are Bulgaria, Czechoslovakia, France (Alsace-Lorraine), Germany, Great Britain and Northern Ireland, the Irish Free State, Latvia, and Lithuania. On the other hand, the laws of certain countries expressly exclude or fail to include civil servants and workers in State undertakings without stipulating for equivalence of treatment, although this condition is probably fulfilled (Greece and Luxemburg).

In Germany officials, medical practitioners, and dentists in services or undertakings of the States or Federal Government and the communes are excluded from the general scheme, provided that they are guaranteed a minimum right against their employer either to benefits in cash and in kind equal in amount and duration to the statutory benefits of the general scheme, or to an allowance equal

to $1\frac{1}{2}$ times the pecuniary sick benefit of the general scheme, and payable for at least 26 weeks. Public officials and employees of public bodies other than those mentioned above (artisans' guilds, medical associations, etc.) may be exempted on the application of their employers if they are entitled in the event of sickness to the same privileges as State officials or employees. Persons employed in the public services but not in permanent appointments are insured under the general scheme (except persons who are undergoing training and are therefore exempt.).

Great Britain and Northern Ireland and the Irish Free State possess identical legislation on this subject. Here exclusion applies to persons employed by the State or by local or other public authorities, and to clerks or salaried officials in the service of companies established by statute, e.g. railway companies, who are entitled to rights in a statutory superannuation fund. Exclusion is contingent on the employer's obtaining from the competent Minister a certificate that the terms of employment are such as to secure provision in respect of sickness and also invalidity on the whole not less favourable than the corresponding benefits under the general scheme, which, it must be remembered, covers both these risks. It is not required that the benefits provided by the terms of employment should be precisely on the same lines as those of the general scheme, but it is necessary that their actuarial value should be at least equally great. The effect has been in Great Britain to exclude practically all established civil servants, the police, the majority of poor law and asylum officers, the permanent clerical staffs of many county, borough and district councils, nearly all pensionable railway clerks and officials, and the permanent officials of a few statutory companies, numbering in all about 350,000 persons.

Finally, in Lithuania State civil servants with pension rights, and in Bulgaria persons employed by the State or local authorities whose salary is subject to deduction with a view to superannuation are not liable to compulsory insurance, but may insure voluntarily. Other workers engaged in public services or undertakings are insured under the general scheme.

HOME WORKERS

Home workers form a class intermediate between ordinary wage-earners on the one hand and fully independent workers on the other. The characteristic which differentiates home workers from ordinary wage-earners is that they work, not in the factory

of their employer, but in their own homes or workplaces. On the other hand, they are distinguished from independent workers by the fact that they work exclusively for one or perhaps several employers. There are numerous varieties of home workers: thus, the home worker may work under contract exclusively for one employer by whom he is supplied with tools and materials; or he may work with his own equipment, supply his own materials and employ several assistants, the sole connection between him and his employer being an agreement as to the price to be paid for the finished product. Many home workers, especially women, earn but small wages, and they therefore require the protection of insurance in the same degree as the factory worker. Hence they have been usually comprised within the scope of compulsory sickness insurance, and in particular are liable to insurance in the following countries: Austria, Czechoslovakia, Germany, Great Britain and Northern Ireland, Hungary, Irish Free State, Latvia, Norway, Poland, Russia, and the Serb-Croat-Slovene Kingdom. In Bulgaria, Greece, and Lithuania home workers may insure voluntarily in the general scheme.

In many countries it was for the purpose of compulsory insurance that it became necessary to define home workers, and the definitions differ somewhat in detail. The terms used in the laws are sometimes rather vague, and it would not be possible to form a clear conception of their meaning except by a study of legal decisions, which cannot be undertaken here. All that can be done is to cite a few characteristic provisions.

In Russia a home worker is liable to insurance if the raw materials are supplied by the employer and he works without assistants, provided that he is not producing for the personal requirements of the employer.

According to the British Act, an outworker is a person who works either at home or in some other place not under the employer's control and is engaged in making up or altering articles given out to him by the employer for the purposes of the latter's trade or business. In German legislation a distinction is made between outworkers (*Aussenarbeiter*) and persons engaged in home industry (*Hausgewerbetreibende*). The former are insured under the same conditions as ordinary wage-earners, while the latter, who enjoy a greater degree of economic independence, are only insured provided that their annual earnings do not exceed 3,600 marks.

The Austrian law applies compulsory insurance to home workers, middlemen, and intermediaries.

The Hungarian and Yugoslav laws cover home workers engaged in work for wages in their own workplace by order and on account of an employer, even if they provide their own raw materials and tools and work on their own account.

In Czechoslovakia home workers are liable to insurance if they work regularly for one or more employers. The law moreover makes provision for the extension of insurance to home workers who do not work exclusively for one or more employers, but also who work for private customers.

Lastly, the Polish Act gives an even wider definition: insurance is compulsory for any person working either in his own place of residence or in a workshop, solely or mainly on account of one or more employers, even if he furnishes his own materials and tools, and employs members of his family or other workers, provided that the said home work constitutes his principal means of subsistence.

§ 3. — Limitations Arising Out of the Occasional or Temporary Character of Employment

OCCASIONAL AND SUBSIDIARY EMPLOYMENTS

Wage-earning work, if it is to involve liability to insurance, must be the ordinary means of livelihood of the worker, or at least be of substantial economic importance to him. Hence, in general, no account is taken of employment which is only taken up occasionally by a worker, or of employment which affords only an insignificant portion of the income necessary for his subsistence.

Employments which are commonly excluded from the scope of compulsory insurance on the ground that they are not the ordinary or principal means of livelihood may be divided into two classes:

Occasional employment.

Subsidiary employment.

*Occasional Employment*¹

(Travail occasionnel; vorübergehende Dienstleistungen)

A person who only engages in wage-earning work from time to time and who consequently has, or may be presumed to have,

¹ There is no term in British social insurance legislation whose meaning corresponds to the definition of *travail occasionnel* or *vorübergehende Dienst-*

other means of livelihood, is an occasional worker, and his work is occasional employment.

Although it is not the primary characteristic of occasional employment that it should be of brief duration, yet clearly an engagement which lasts a substantial period must become of economic importance to the worker, and accordingly an engagement which exceeds a certain duration cannot be regarded as an occasional employment.

The majority of sickness insurance laws exclude occasional workers from their scope. Moreover, it is generally provided that occasional employment must be of limited duration if it is to entail exclusion.

The German legislation and that of Alsace-Lorraine decide whether occasional employment (*vorübergehende Dienstleistung*) is to involve insurance according as the worker is or is not dependent upon wage-earning work for his subsistence: they provide moreover that the duration of such employment must be limited either by its nature or by contract to less than one week.

The Latvian and Polish laws only cover temporary workers who derive their livelihood principally from wages; in effect therefore they exclude occasional workers. The Polish Act, however, makes all workers liable to insurance if their employment exceeds five days. The legislation of Esthonia and Lithuania resembles the Polish Act in that it excludes occasional workers, but does not maintain the exclusion if the worker is employed for a period exceeding in Esthonia one week, and in Lithuania one month.

According to the Austrian Act persons who are engaged in employment liable to insurance only occasionally and temporarily (*gelegentlich und vorübergehend*) are excluded. A similar expression is encountered in the Yugoslav Act, where power is taken to exempt any person who becomes liable to insurance only at intervals on account of occasional and temporary employment for wages.

The Czechoslovak Act merely states that persons who perform work by way of occasional employment (*gelegentlich*) are excluded. Occasional employment is, however, interpreted to mean, as in

leistungen "Employment of a casual nature" occurs in British legislation, but in spite of the similar etymology of "casual" and "occasional", it resembles rather the conception of "temporary" employment as understood in Continental legislation. It has therefore been considered preferable, in order to avoid confusion, to use the novel but colourless term 'occasional employment'.

Germany, employment in which a person engages on single occasions and which is not the main source of his livelihood.

In Great Britain, Northern Ireland, and the Irish Free State persons who perform work for wages only occasionally are in principle liable to insurance. Nevertheless, such persons may, at their request, be exempted if they can prove that they are ordinarily dependent for their livelihood upon an occupation which does not imply liability to insurance, or that they have been employed for less than 13 weeks during each of the two years preceding their application for exemption.

Subsidiary Employment (Travail accessoire; Nebenberuf)

An employment is called subsidiary in which the worker gives only part-time service, being engaged actually or presumably in another occupation which provides him with his principal means of subsistence. For the purpose of liability to insurance the situation of persons engaged in subsidiary employment differs according as the main occupation is or is not an employment involving liability to insurance. If the main occupation entails insurance, then the subsidiary employment is *ipso facto* always exempt. The question remains whether a person not otherwise liable to insurance becomes liable if he engages in a subsidiary employment. The majority of the laws do not mention subsidiary employment: one may therefore infer that for liability to insurance under these laws the proportion of the working time occupied by an employment is without consequence. Provisions relating to subsidiary employment are found in the laws of six countries only: Austria, Czechoslovakia, France (Alsace-Lorraine), Germany, Great Britain and Northern Ireland, and the Irish Free State.

The first four of these countries have adopted the same criteria for deciding whether subsidiary employment involves insurance: regard is had in each case to the degree in which the person engaged in an employment is dependent upon it for his livelihood. No list of occupations in which employment is deemed to be subsidiary is prescribed, but each case is considered individually. The Austrian and Czechoslovak Acts simply provide that persons who perform work by way of subsidiary employment are exempt. The German legislation, which is also in force in Alsace-Lorraine, exempts persons not performing elsewhere paid work by way of trade (*berufsmässig*) who only work from time to time (though the

intervals may be regular) by way of subsidiary occupation (*nebenher*) and who receive remuneration which does not contribute substantially to their livelihood.

The policy of the British Act and the derived legislation of the Irish Free State is slightly different. Subsidiary employment is defined absolutely by the nature of the work and not with reference to the dependence of the particular worker upon it. These laws provide that liability to insurance shall not arise from the exercise of any employment designated by order as being of such a nature that it is *ordinarily* adopted as a subsidiary employment only and not as the principal means of livelihood. Orders have been issued enumerating such employments. A few of these may be cited as examples: church organist, part-time postal worker, member of fire brigade, club secretary, deliverer of newspapers. The characteristic of these employments is that they involve part-time service only, so that the workers concerned may be presumed to be engaged in another and principal occupation: whether they are in fact so engaged is immaterial. The British law also includes among subsidiary employments certain kinds of seasonal agricultural work, but in this case exclusion is conditional upon the question of fact whether the person is insured at the time of taking up such work, i.e. whether he is ordinarily a wage-earner.

TEMPORARY EMPLOYMENT

(*Travail temporaire; unstandige Beschäftigung*)

An essential part of the mechanism of wage-earners' insurance is the payment of a share of the contribution by the employer and the deduction of the worker's share from his wages. The operation of this mechanism is rendered difficult in the case of workers who frequently change their employer, or who work for several employers alternately, though under regular agreements.

Persons whose period of continuous work under any one employer is short are found in many trades: that of the docker, who must seek a fresh engagement day by day, is perhaps typical. Temporary workers (who are distinguished from occasional workers by the fact that their ordinary means of livelihood is wage-earning work) evidently require the protection of insurance as much as other wage-earners. Accordingly the laws of a number of countries prescribe special measures to meet the need of such workers for insurance, while in other countries, on the contrary, the difficulties

have been considered insurmountable, so that workers the duration of whose engagement by any one employer is less than a prescribed period are excluded.

The countries where temporary workers are liable to insurance, regardless of the shortness of their engagement are as follows:

Austria	Hungary
Bulgaria	Latvia
Czechoslovakia	Poland
France (Alsace-Lorraine)	Serb-Croat-Slovene Kingdom.
Germany	

The special provisions for the insurance of temporary workers made by the laws of the above countries relate to the notification of employment to the insurance institution and the payment of contributions. For the purpose of the application of these measures, temporary workers are defined in the laws of Austria, Czechoslovakia, France (Alsace-Lorraine), and Germany as those whose employment under any one employer is usually less than one week.

In Great Britain and the Irish Free State casual employment does not quite correspond either with occasional employment or with temporary employment as understood in Continental legislation. The British Act does not insist expressly either on the duration of the employment or upon the importance of wages in the means of livelihood of the worker. It brings in two factors which are peculiar to it: on the one hand the irregularity of the employment of a particular worker by a particular employer, and on the other hand the relation of the work performed to the employer's trade or business. It excludes from its scope every person whose employment is casual and who works otherwise than for the purposes of the employer's trade or business. Thus by casual employment is meant a chance or accidental employment which does not involve an agreement with the employer as to the periodicity of the work, even if the worker concerned depends ordinarily upon his work as his sole means of subsistence. On the other hand, casual or temporary workers engaged for work in connection with the employer's trade or business are always liable to insurance, however short their employment. In effect, the exception allowed by the British Act in respect of casual employment applies almost entirely to private domestic establishments and only excludes a very small number of persons who regularly work for wages.

In a few countries employment of less than a prescribed duration is simply excluded from the scope of insurance. Thus, a person whose livelihood is earned by the performance of tem-

porary jobs in succession cannot be insured. Such is the case in Japan and Luxemburg. In the latter country a person whose occupation by reason of its object or in accordance with the terms of the engagement will last for less than a week is excluded from insurance. The Japanese law excludes persons who are employed either for a fixed period of less than 60 days, or by the day up to 30 days, or on other terms as may be prescribed. In Norway also persons whose employment cannot exceed six days by reason of the nature of the work are exempt from insurance, but the operation of this rule may be suspended in the case of prescribed classes, and an exception has in fact been made in the case of dockers.

Employment by way of trade by more than one employer at regular intervals is not mentioned in the majority of laws.

The Austrian law alone expressly provides that persons employed by more than one employer shall be insured; such persons are insured whether they are employed for part of the day by each employer or for several consecutive days by each. The Norwegian law removes any doubt as to the liability of such persons by prescribing that it is not a condition for liability to insurance that the hours of work should be consecutive or occupy the entire working day.

The other laws assume that persons working for more than one employer are liable to insurance, and simply prescribe special regulations relating, e.g., to the payment of contributions. Thus the law which is in force in Germany and Alsace-Lorraine, and likewise the British and Irish legislation, prescribe that the first employer in the week is liable for the payment of the contribution. The Czechoslovak and Yugoslav Acts make the several employers jointly responsible for the contribution.

Some of these laws mention typical examples of persons employed by several employers. Thus the Austrian Act enumerates tutors, sick nurses, seamstresses, and charwomen; the Czechoslovak Act also refers to seamstresses and charwomen; and in Latvia washerwomen, charwomen and in general persons working for more than one employer are likewise subject to insurance. The British and Irish laws prescribe that where an agent paid by commission is employed as such by more than one employer, but is mainly dependent on one employer for his livelihood, contributions are payable by that employer, whilst such an agent who is not dependent on any one employer is not liable to insurance at all.

Seasonal employment is usually a variety of temporary employ-

ment. It is most frequently associated with agriculture and its accessory industries (e.g. sugar refining), but it is also found in many other occupations and branches of industry, such as building and hotel-keeping, or fish-canning, which depends upon the fishing season. Although seasonal employment is naturally of limited duration, it may nevertheless occupy a substantial portion of the year, and the worker may rely upon it as his principal means of livelihood. On the other hand, seasonal employment may be merely occasional for the worker who is not ordinarily a wage-earner.

There are few laws which make specific reference to seasonal employment. In the absence of such reference seasonal employment would be treated as temporary or occasional employment according to the particular case.

The British and Irish laws exclude certain seasonal employments unless the persons engaged in them were already insured at the time of taking up the work: in this way the protection of the genuine wage-earner is secured, while the person who takes up seasonal work occasionally, not being a wage-earner at other times, is excluded. Seasonal employments include those of fruit-picker, hop-picker, hop-tier, and pea-picker.

The Bulgarian Act unconditionally excludes mowers, vine-dressers, rose-pickers, wood-cutters, and tree-fellers.

In Russia seasonal workers in prescribed occupations are excluded if their employment lasts less than one month; in other occupations they are insured.

§ 4. — Limitations Arising Out of the Personal Qualifications of Workers

PHYSIOLOGICAL CONDITIONS

Age Limits

The factor of age would seem to be immaterial so far as compulsory sickness insurance is concerned. At whatever age a person is engaged in employment he is to be presumed to depend upon his work for his livelihood and consequently to require maintenance as well as medical aid in case of sickness. This has evidently been the view of the great majority of legislators, who have prescribed neither minimum nor maximum age limits. A minimum

limit is, as a matter of fact, in most countries introduced by another agency, namely, by the legal provisions concerning the minimum age for the admission of children to employment.

In three countries only are age limits laid down. In Norway there is a minimum age of 15, while the British and Irish laws prescribe both a lower limit of 16 and an upper limit of 70 (reduced to 65 as from the beginning of 1928 in Great Britain and Northern Ireland only).

In the case of the British law a Royal Commission decided recently that the age limits should be retained. The lower limit does not coincide with the school-leaving age, which is 14, but it is considered that in the face of a tendency to raise the latter to 16 it would be inadvisable to lower the insurance age. Moreover, the Commission urged that there were serious practical objections. Cash benefits are paid at flat rates, there being but one full rate of benefit for each sex. It would be necessary, if the age limit were lowered, to introduce a special reduced scale of contributions and benefits or else to reconsider the financial basis of the insurance scheme. When a person reaches the upper limit, he does not cease to be insured, but he is no longer entitled to any sickness or invalidity benefit; he retains, however, the right to medical benefit for life, whether he remains at work after reaching the limit or not. The upper limit moreover coincides with the age at which the old-age pension becomes payable. The Commission thought it undesirable that a person should be able to receive both sickness benefit and pension at the same time¹. The pension, it may be remarked, while lower than sickness benefit is greater than the disablement benefit fixed under sickness insurance, and the pensioner's wife is also entitled to a pension.

Working Capacity

It is in accordance with the general conception of social and especially compulsory insurance that the factor of health should not be taken into account in the determination of liability to insurance. There is nevertheless one aspect in which health cannot be disregarded. A person must, when he becomes insured be initially capable of work, since otherwise he would not be employed. The question is whether full working capacity is necessary or not.

¹ *Report of the Royal Commission on National Health Insurance*, pp. 195-196.

The policy of the vast majority of countries is that if a person is regularly employed, he shall be insured, whether his capacity for work is entire or diminished. There are three schemes, however, in which special provision is made for invalids, namely, those of Germany, Norway and Russia.

According to the German law, invalids are allowed to be exempted from compulsion to insure if they are in receipt of an invalidity pension and if furthermore the poor relief authority which is liable for their maintenance consents. Exemption is also granted at their request to workers who have exhausted their right to sickness benefit for as long as they are unable to work or continue to need medical treatment for the same illness. It would indeed be useless to compel workers to pay contributions if they have exhausted their right to benefit and are therefore unable to obtain further relief.

Voluntary exemption is likewise admitted in Norway for the convenience of invalids. A sick fund may exempt from insurance a person whose earning capacity is seriously impaired as a result of chronic illness or other permanent infirmity. The provision is explained, as in the case of Germany, by the desire to spare the invalid the loss of contributions for which he can obtain no return after exhausting his right to benefit.

Not all invalids are excluded from the operation of the Russian scheme, but only those who are employed in undertakings organised by the Commissariat of Social Assistance or who belong to invalids' co-operatives: those who work in other undertakings are necessarily subject to insurance.

POLITICAL AND CIVIL CONDITIONS

Nationality

All sickness insurance laws as a general rule disregard the nationality of the wage-earner as a qualification for admission to insurance. Sometimes the law provides expressly for the assimilation of nationals and foreigners, but more often the matter is not mentioned, and from this silence one may deduce that assimilation exists in practice. While in no country are aliens absolutely excluded, yet several laws contain a reservation enabling retaliatory measures to be exercised against them.

So far as sickness insurance is concerned, the Bulgarian and Hungarian laws treat aliens on exactly the same footing as their

nationals, though for other branches of insurance equality of treatment is conditional upon reciprocity. The British and Irish laws are applied in actual fact irrespective of nationality, but power, which has never been exercised, is given in the law to prescribe special conditions for aliens.

Four other laws make more definite provision for the possibility of reprisals. Thus, while the German law applies in principle with equal force irrespective of nationality, yet the Government may instruct that retaliation should be exercised against persons of foreign nationality and their dependants. Such a step might, for example, be taken if, according to foreign legislation, Germans had to pay insurance contributions but obtained no benefits in return. On the other hand, power is also taken to conclude reciprocal agreements with other States concerning the liability to insurance of persons temporarily employed outside their own countries and concerning the situation for the purpose of insurance of undertakings whose activities overlap national boundaries. It has been prescribed by order that aliens who are employed in frontier districts for a limited period may be exempted from insurance with the approval of the local authorities.

Foreigners are in principle insured under the same conditions as nationals in Czechoslovakia. Nevertheless conditions may be modified for foreigners according as the treatment of Czechoslovak nationals by foreign States is equal or unequal. As in the German law, it is provided that international agreements may be concluded for the purpose of making exception to the rules governing liability to insurance.

An alien employed in the Serb-Croat-Slovene Kingdom is to be treated on an equality with nationals of the Kingdom, but special rules can be issued concerning the treatment of nationals of States which possess social insurance systems but do not treat Yugoslavs in the same manner as their own subjects.

A special law, dated 6 July 1923, has been passed in Poland to regulate the situation of foreigners with regard to insurance. It confirms the equality of treatment which foreigners already enjoy in the matter of sickness insurance but enables retaliatory measures to be taken against the States which do not grant equal treatment to Poles resident within their territories.

Family Relationship with Employer

The fact that family relationship exists between the employer and worker may in certain cases modify the liability of the latter

to compulsory insurance. There are two aspects of such cases which must be considered: the genuineness of the employment and the obligation of the employer to maintain his relative. In general, but not always, one of these aspects presents itself to the exclusion of the other. The former as a rule implies insurance, while the latter yields a reason for exclusion.

In the majority of countries the legislator has not thought it necessary to make any special provision concerning the employment of relatives: he has simply left each case to be settled by reference to the criterion of genuine employment. Where work is performed, e.g., by a wife in the household, without an agreement or specific remuneration, the essential characteristics of employment are absent, and such work cannot therefore give rise to liability to insurance. The position is quite different when the member of the family is employed regularly for remuneration in the undertaking, or even in the household of his relative: in this case, the worker will be subject to compulsory insurance. Such is the situation in Czechoslovakia, Esthonia, Hungary, Japan, Latvia, Lithuania, Poland, Russia, and the Serb-Croat-Slovene Kingdom.

The laws of the remaining countries, however, prescribe special rules applicable to persons working for their relatives. For the purpose of studying these rules it is convenient to consider separately the situation of the wife (or husband), children, and other relatives.

Employment of Wife by Husband or vice versa

In view of the permanent claim of the wife to be supported by her husband and vice versa, several laws take the position that, even if a contract of service exists, liability to insurance cannot arise where the parties concerned are husband and wife. Provisions absolutely excluding from insurance the wife when employed by her husband and vice versa are found in the laws of Austria, Bulgaria, Great Britain and Northern Ireland, the Irish Free State, France (Alsace-Lorraine), and Germany.

Employment of Children by Parents

A variety of solutions have been given by the different laws to the problem created for insurance by the employment of children by their parents.

In the first place, there is the absolute exclusion of minor children in Bulgaria, doubtless by reason of the legal obligation of maintenance.

Then, the Austrian law excepts the children (legitimate, illegitimate, or adopted) of the employer, irrespective of their age, if they are not remunerated in the usual manner and degree. The exception, however, no longer applies if the children work in an agricultural undertaking, unless at least one worker liable to insurance is also employed. In this case, however, the children may still be exempted on the application of their parent if he undertakes to care for them during sickness.

Similarly the British, Irish, and Norwegian laws exclude children who are employed by their parents without wages or other money payment.

The exemption of children from the scope of insurance under the German law is conditional upon the application of the parent who employs them; exemption is, however, allowed only in the case of apprentices.

Employment of Other Members of the Employer's Family

When the person employed is not the wife or child of the employer but another, and perhaps more distant, relative, it is likely that his connection with the employer will tend to resemble that of an unrelated wage-earner. This is so far true of collateral relatives that no law makes any provision for excepting them.

The employment of parents, grandparents and grandchildren is probably rare, and although there exists in most (if not all) countries a legal obligation on the part of ascendants and descendants to support one another, it has generally been considered that, for the purposes of insurance, they should not be differentiated from other wage-earners. The laws of two countries only, Austria and Bulgaria, prescribe the conditional or absolute exclusion of these members of the employer's family.

In Austria ascendants and descendants are excluded if they are not remunerated in the ordinary manner and degree; if, however, the employment is in agriculture, they are excluded only on condition that at least one worker liable to insurance is also employed. Other members of the employer's family may be exempted on condition of equivalent treatment, in the same way as children.

The Bulgarian law excludes absolutely ascendants and minor descendants.

ECONOMIC CONDITIONS

Maximum Earnings or Income

Compulsory insurance may cover all the wage-earners in the undertakings or occupations to which it applies, or it may confine its protection to workers whose incomes do not exceed a prescribed limit. On the assumption that the object of insurance is to repair the loss occasioned by sickness so that the standard of living of the sick person is wholly or partially maintained, no means limit will be imposed. If, on the contrary, it is considered that insurance should only be made compulsory for persons of small means, then a means limit is required in order to exclude higher-paid workers who are deemed capable of taking provident measures on their own account. The imposition of a means limit may also be explained by a desire to lighten the financial burden on production.

Both policies are represented in national legislation. In Germany, Great Britain and Northern Ireland, Hungary, the Irish Free State, Japan, Lithuania, Luxemburg, and Norway, a maximum limit of earnings or income is prescribed, whereas in Austria, Czechoslovakia, Esthonia, Latvia, Poland, Russia, and the Serb-Croat-Slovene Kingdom, liability to insurance arises irrespective of means.

In Germany, Great Britain and Northern Ireland, Hungary, the Irish Free State, Japan, Luxemburg, and Norway, the means limit operates only in the case of non-manual workers. The justification put forward for applying the limit to this class only is that non-manual workers are commonly paid a monthly salary which they continue to receive for a certain period, that their tenure of employment is more secure and that they have a stronger tendency to save and insure on their own initiative than manual workers.

The means limit may be calculated on the basis either of wages alone or of all income from whatever source — interest or pension, etc. In one country only, namely, Norway, is the entire income taken into account, while in the other countries regard is had solely to remuneration for labour: earnings, wages, or salary. Doubtless it was considered by the majority of legislators that the number of wage-earners possessing private means was exceedingly small, and that it was not worth while to undertake the administrative expense of detecting such wage-earners and measuring their unearned incomes.

When an insurance scheme provides for an income limit, the scope of the scheme, and therefore to a large degree its social value, depends on the level at which the limit is fixed. An examination of the laws does not reveal any common rule for the adjustment of the level. It is probable that in each country a compromise has been effected into which enter the general level of wages and various social and political considerations.

In the following table are summarised the provisions of the laws concerning the income limit for the purpose of liability to compulsory insurance.

MAXIMUM LIMIT OF ANNUAL EARNINGS OR INCOME

Country	Class of worker	Source of income	Maximum rate
Germany	Non-manual	Earned	3,600 marks
Great Britain and Northern Ireland	do.	do	£250
Hungary	do.	do	24,000,000 crowns
Irish Free State . .	do.	do	£250
Japan	do.	do	1,200 yen
Lithuania	All	do.	4,800 litas
Luxemburg	Non-manual	do.	10,000 francs
Norway.	do.	All	6,000 crowns

A few laws take income into account, not in order to exclude workers whose income exceeds a prescribed limit, but in order to allow such persons to obtain exemption from liability to insurance at their own request. Such provisions operate in Great Britain and Northern Ireland, the Irish Free State, and Poland. According to British and Irish legislation insured persons may be exempted at their own request if they possess an independent income of at least £26 a year (this rate corresponds to that of sickness benefit as originally fixed by the Act of 1911). Exempt persons remain entitled to medical benefit, and employers continue to be required to pay their share of the contribution, both in order to meet the cost of this benefit and to counteract any tendency to employ persons with private means. The Polish law provides similarly for voluntary exemption, but the privilege is open only to the managers of undertakings whose annual salary exceeds 7,500 zloty.

§ 5. — Application of Insurance to Non-Wage-Earners

APPRENTICES

An apprentice is bound to his employer by a contract, which may be expressed or implied, to give his services in return for instruction. Sometimes he receives a small wage, but often he is not remunerated except perhaps in kind. Apprentices who are paid in money are covered by all compulsory insurance schemes. On the other hand, unremunerated apprentices are, in several countries, considered to incur no economic loss during sickness: such is the attitude of the legislation of Esthonia, Great Britain and Northern Ireland, Greece, and the Irish Free State. The British and Irish laws exclude apprentices who receive no money payment or are under the age of 16.

PERSONS WORKING ON THEIR OWN ACCOUNT

Certain categories of persons working on their own account, such as small craftsmen and shopkeepers, who do not work under a contract of labour, are frequently in an economic situation no better than that of wage-earners. Their business often yields but small profits, and they may need the protection of insurance just as much as wage-earners. Nevertheless they are covered only by a few compulsory insurance laws.

Apart from countries dealt with in Chapter II, Roumania is the only one where a considerable proportion of independent workers are compulsorily insured. Its insurance scheme is based upon the guild organisation, in which are included not only apprentices and journeymen but masters.

In a few other schemes which are intended primarily for wage-earners, small classes of independent workers are liable to insurance, but such workers represent an insignificant fraction of the total insured population.

In France (Alsace-Lorraine) and Germany, teachers, tutors, and home workers (*Hausgewerbetreibende*, who are regarded as independent by the German Insurance Code) are liable to insurance if their annual earnings do not exceed 10,000 francs and 3,600 marks in the respective countries.

Under the Latvian law, the Minister of Social Welfare may render liable to insurance the owners of small-scale undertakings who work themselves and have not more than three assistants; an Order, dated 2 June 1923, has been issued enabling them to insure voluntarily. A provision of similar character is to be found in the Luxemburg law. The Yugoslav law enables the Minister of Social Affairs to apply compulsory insurance, on the one hand, to the skippers of small seagoing vessels who are the employers of their crews, and, on the other hand, to independent craftsmen working in their homes. It does not appear, however, that use has yet been made of the powers conferred by these last two laws.

§ 6. — Voluntary Insurance

The scope of compulsory insurance is, as we have seen, confined almost entirely to wage-earners. The rigid application of employment as the criterion of liability to insurance results in the exclusion of an important section of the population who, although not employed, have, on the ground of smallness of means, the same need for insurance as wage-earners. In particular, two classes are excluded: firstly persons who for any reason give up employment either temporarily or permanently and secondly independent workers of small means. No doubt it is often possible for such persons to cover their risk by insurance with mutual benefit societies or other voluntary institutions. On the other hand, there will be many persons for whom this solution is not satisfactory: voluntary institutions may be few or non-existent, their arrangements for medical aid may be defective, or their cost may be too high, or, finally, admission to insurance may be conditional upon good health.

It is therefore that most wage-earners' insurance schemes, though the vast majority of the persons covered by them are insured compulsorily and their organisation is determined accordingly, provide some measure of voluntary insurance, the scope of which is generally restricted to certain classes. A health test is sometimes imposed as a condition of admission, and the insured person has to pay the entire contribution himself. It is perhaps because of these conditions that complementary voluntary insurance with the institutions of compulsory schemes has hitherto acquired comparatively little importance.

Two classes are usually envisaged by the voluntary provisions of sickness insurance laws: persons who cease to be liable to compulsory insurance, and independent workers, the first of these being partly a sub-class of the second. The voluntary provisions may sometimes be the same for either class, but more frequently a distinction is made between persons who have, and those who have not, already been insured compulsorily. We shall describe firstly the provisions concerning the continued insurance of persons formerly compulsorily insured; and secondly the provisions concerning voluntary insurance proper.

CONTINUED INSURANCE FOR PERSONS PREVIOUSLY INSURED COMPULSORILY

A person ceases to be liable to compulsory insurance whenever he fails in some particular to comply with the conditions under which he originally became liable. There are, however, two principal occasions for cessation of liability: when a person leaves employment and, if he is a non-manual worker, when his income exceeds the maximum limit. Apart from the case of women who give up work on account of marriage, a person generally leaves employment in order to take up some independent occupation, in which, however, the earnings are likely to be but little higher than in employment, and often he will return again to employment. In many cases therefore the person continues to belong to that economic stratum of society whose needs sickness insurance is intended to meet. The admission to voluntary insurance of persons whose income is above the prescribed maximum may be urged on the ground that they still need insurance, although they can dispense with the employer's contribution, and, in the case of certain types of worker, that the higher income is precarious and does not mark a definitive and considerable improvement of economic status. There is also the argument that a person who has been compelled to contribute for a considerable period should have the opportunity of maintaining his insurance if he so desires.

Provision for continued insurance is made in the compulsory sickness insurance laws of the following countries:

Austria	Irish Free State
Bulgaria	Japan
Czechoslovakia	Lithuania
France (Alsace-Lorraine)	Luxembourg
Germany	Norway
Great Britain and Northern Ireland	Poland
Greece	Serb-Croat-Slovene Kingdom
Hungary	

Some of these laws, however, do not distinguish persons formerly insured from others for the purpose of admission to voluntary insurance, and their provisions are accordingly described below in connection with voluntary insurance proper. The laws in question are those of Bulgaria, Greece, Lithuania, Luxemburg, and the Serb-Croat-Slovene Kingdom.

Admission is made much easier for persons formerly liable to compulsory insurance than for those who first enter as volunteers. The former are admitted regardless of health or age. It is natural that in the absence of these restrictions the option of continuing to be insured will be exercised in a sense unfavourable to the insurance institution, since those who choose to continue in insurance are likely to represent heavier risks than the average insured person. This possibility of heavier risk may, however, be safely neglected, seeing that in fact the volume of voluntary insurance is insignificant in comparison with that of compulsory insurance.

It must not be supposed, however, that there are no conditions at all for admission to continued insurance. On the contrary five types of conditions are found in the laws: they relate to the income, nature of the occupation, sex, duration of compulsory insurance, and period of grace in which the application to enter voluntary insurance must be made.

The first of these is the most effective restriction, but is prescribed in the laws of one country only. The maximum annual income is 8,400,000 crowns in Hungary, and applies solely to non-manual workers. In this connection attention must be drawn to a peculiarity of the Hungarian law, which is that the income limit applicable to compulsorily insured persons is very much higher, being 24,000,000 crowns a year. It does not appear, however, that a person having once become voluntarily insured would be required to resign because his income exceeded the prescribed maximum.

Two classes of persons only may take advantage of continued insurance according to the Hungarian law: those who leave insurable employment but remain essentially wage-earners, and the unemployed. No such restriction is found in other laws.

The exclusion of married women from continued insurance on a voluntary basis, even if they marry after they have been admitted, is a peculiarity of the British and Irish laws.

The next condition is that the applicant for admission to voluntary insurance is required to have completed a minimum period of compulsory insurance. This condition is specified in seven of the laws, and is apparently intended to prevent persons who have not

been regular wage-earners from benefiting by the opportunity of voluntary insurance. The minimum periods are as follows:

Great Britain and Northern Ireland, and Irish Free State: 104 weeks, which need not be continuous, provided that the intervals are not long enough to interrupt membership of the insurance institution;

Germany and France (Alsace-Lorraine): 26 weeks during the previous 12 months or not less than 6 weeks immediately before leaving;

Hungary: 6 months during the previous year or 12 months in the course of the previous 2 years;

Japan: 180 days during the previous year, or 60 days immediately before leaving;

Czechoslovakia and Norway: 3 months immediately before leaving.

If a person, having ceased to be liable to compulsory insurance, were to be allowed to re-enter as a voluntary contributor at any time, it is obvious that there would be a strong tendency for him to wait until he actually became ill or debilitated before he would apply for admission. It is indispensable therefore to prescribe some maximum period within which application to enter continued insurance must be made. These periods differ widely:

12 months in Great Britain and Northern Ireland and the Irish Free State;

4 weeks in Austria, Czechoslovakia, Hungary and Poland;

3 weeks in Germany and French provinces of Alsace-Lorraine;

10 days in Japan;

1 week in Norway.

The explanation of the long period allowed by British and Irish legislation is to be found in the fact that these laws provide at the same time for sickness and invalidity insurance, and that the right to an invalidity allowance depends upon the completion of a two years' probationary period of insurance. It is necessary therefore that insured persons who have completed these two years should be given an ample opportunity to keep alive their privileges. In the other countries, where sickness insurance is separate, and little or no probationary period is imposed, it is not unfair to prescribe a shorter period in which a person may exercise his option. Moreover, under the British and Irish system, insurance remains effective in any event for 12 months after contributions

cease to be compulsory payable and it is natural that the insured person should be allowed the same period in which to decide whether he will continue his insurance on a voluntary basis.

Once admitted to continued insurance persons may remain insured in all circumstances, provided that they remain within the country and pay their contributions regularly. Usually a person is allowed to fall into arrears with his contributions for a few weeks before he ceases to be insured. Such is the case, for example, in Austria, Germany, France (Alsace-Lorraine), and Poland, where the period of grace is four weeks. Again, however, the British and Irish laws provide an exception, as has just been indicated: here the period of grace is extended to twelve months.

VOLUNTARY INSURANCE FOR PERSONS OUTSIDE THE SCOPE OF COMPULSORY INSURANCE

The population which is outside the scope of compulsory insurance consists on the one hand of dependants, who are or may be protected by the insurance of their breadwinners, and persons having private incomes, and, on the other hand, of groups of wage-earners who for any reason are not liable to insurance, and independent workers. These latter classes of excluded wage-earners and independent workers earn their livelihood by their work, and hence require insurance if their standard of living is to be maintained in case of sickness. Independent workers are of all degrees of wealth, but the majority of them are of small means, and are little better able to carry the risk of sickness themselves than the wage-earners.

In compulsory sickness insurance schemes designed for wage-earners almost the only provision for the independent worker is made by way of voluntary insurance. Not all schemes possess this feature, but only those of

Bulgaria	Lithuania
France (Alsace-Lorraine)	Luxemburg
Germany	Norway
Greece	Poland
Hungary	Serb-Croat-Slovene Kingdom ¹
Latvia	

In none of these countries is voluntary insurance open without restriction to every person not covered by compulsory insurance,

¹ In this country the conditions under which a person may insure voluntarily have not yet been prescribed.

but two sets of conditions, the one economic and the other physiological, are as a rule imposed.

The economic conditions are designed to restrict the opportunity of voluntary insurance to persons whose occupation or income makes it reasonable to suppose that they need the convenience and security of insurance in the institutions of a compulsory scheme. Sometimes both the occupations are defined and an income limit is fixed as well; sometimes only one of these conditions is prescribed; and in the case of Lithuania there is no economic limitation.

In Norway and Poland admission to voluntary insurance is not conditional upon the exercise of a gainful occupation.

On the other hand, in Bulgaria, France (Alsace-Lorraine), Germany, Greece, Hungary, and Luxemburg voluntary insurance is open only to persons engaged in certain specified occupations.

Now, the wider the scope of compulsory insurance, the fewer are the classes of workers for whom voluntary insurance is required. Liability to insurance arises in France (Alsace-Lorraine) and Germany both for wage-earners and home workers, regardless of the industry in which they are employed. Consequently it is only the needs of fully independent workers which have to be provided for.

The scope of voluntary insurance in France (Alsace-Lorraine) and Germany, however, extends only to wage-earners exempt from insurance (seemingly an unimportant class), members of the employer's family working in his undertaking without an agreement, and owners of undertakings employing as a rule not more than two persons liable to compulsory insurance.

The Bulgarian law is more generous, since voluntary insurance is open to independent handicraft workers, persons engaged in commerce, members of the liberal professions, and public servants.

In Latvia owners of small-scale undertakings who work themselves and have not more than three assistants may insure voluntarily.

The laws of Hungary and Luxemburg resemble one another in their definition of the occupations to which voluntary insurance applies. Their compulsory provisions cover neither agricultural workers, domestic servants, nor home workers, except to a very restricted extent, but these classes are enabled to insure voluntarily. Independent craftsmen in Hungary have the same privilege, and likewise owners of small undertakings in Luxemburg, under the same conditions as in Germany. Moreover, the family of the insured person in Hungary, and in Luxemburg the members of

the employer's family working in his undertaking without agreement, have also the right to be insured. Finally the Hungarian law throws open voluntary insurance to all kinds of manual wage-earners and to salaried employees in undertakings and services of the State and municipalities, while in Luxemburg a like opportunity is offered to temporary workers, who are not compulsorily insured.

Contrary to the usual practice in compulsory insurance, an income limit is prescribed for persons desiring to insure voluntarily by the laws of all the countries under consideration except those of Lithuania (which, however, imposes a maximum basic wage) and Greece. In Hungary, the income limit affects salaried employees only. This is the sole restriction, in the absence of any condition relating to occupation, to be found in the laws of Norway and Poland.

Not earnings alone, but income from all sources is taken into account. The maximum rates of annual income applicable to persons applying for admission to voluntary insurance are as follows:

Bulgaria	50,000 levas
France (Alsace-Lorraine)	10,000 francs
Germany	3,600 marks
Hungary	8,400,000 crowns
Luxemburg	12,500 francs
Norway	1,600 crowns in country 1,800 crowns in towns, including income of dependants
Poland	7,500 zloty

The second set of restrictions are physiological: they are intended to safeguard the insurance institution against the heavier risk associated with age and ill-health. Accordingly, sick funds in France (Alsace-Lorraine), Germany, Hungary, and Luxemburg may specify an age limit and may also require a certificate of good health. The Norwegian law prescribes the production of a satisfactory medical certificate by all entrants, and, in the case of non-wage-earners, provides in addition that, if over the age of 50, they shall pay an entrance premium. In Poland only a certificate of good health is required. No physiological conditions appear in the laws of Bulgaria, Greece, or Lithuania.

§ 7. — Territoriality of Insurance Laws

Like any other piece of general legislation, compulsory sickness insurance applies, in the absence of express provision to the contrary,

only within the territory of the State which established it. Application to the territory of other States would be incompatible with international law, and moreover could not as a rule be enforced. In fact, therefore, whether explicitly or implicitly, sickness insurance is, in principle, applicable only to persons within the national territory. The territorial situation of a person is determined for the purpose of insurance, not by his place of residence, but by his place of employment; for it is in virtue of employment that he is liable to insurance and it is through the agency of his employer that the contributions are collected.

If the condition of employment within the national territory admitted no exceptions, it would follow that persons leaving the territory would lose their status in insurance, while conversely those entering the territory would become liable to insurance. These consequences, however, are not in certain cases desirable. Thus if an insured person goes abroad temporarily without leaving his employment, it seems unnecessary to interrupt his membership of an insurance institution; conversely, a person entering the territory for a brief stay, especially if he is already insured, should not be made liable to insurance in a country which he is visiting. When a person goes abroad permanently to a country where no social insurance system exists, it will be an advantage for him to keep up his insurance in his country of origin, provided that benefits can be administered to him.

The territorial conditions governing liability to insurance (as distinct from affiliation to an insurance institution) are rarely set forth in detail in the laws, and indeed more often than not are not prescribed at all. Only the laws of Czechoslovakia, Great Britain and Northern Ireland, Hungary, the Irish Free State, Norway, and the Serb-Croat-Slovene Kingdom deal with this subject. The Hungarian and Yugoslav laws are remarkable in that they extend their scope even to their nationals permanently resident abroad. The laws of the other countries named merely maintain insurance in the case of temporary absence from the country.

The Hungarian law applies in principle to persons who are employed "within the territory of the States of the Holy Crown of Hungary". Furthermore in certain cases its application is extended to persons living abroad. Thus, insurance is compulsory for Hungarian subjects employed permanently abroad, but in the service of a Hungarian firm, provided that they are not already insured under the laws of the State in which they exercise their trade.

A fortiori insurance is maintained in the case of persons who proceed abroad temporarily in the service of a firm in Hungary.

Similar provision is made by the Yugoslav law on behalf of its nationals employed abroad, for liability to insurance applies not only to "every person who performs physical or manual work for remuneration within the territory of the Serb-Croat-Slovene Kingdom", but also to a national temporarily or permanently employed abroad on account of a national undertaking, provided that he is not already insured in the territory in which he is employed.

The territorial principle is clearly stated in Czechoslovak law, which renders liable to insurance "every person who performs work or renders services in the Czechoslovak Republic". It is further provided that the fact of being temporarily employed outside the national territory shall not affect liability to insurance.

Employment within the national territory is likewise stipulated by the British and Irish laws as the primary condition of admission to insurance except in the case of seamen and men of the naval, military or air services. Although with these exceptions employment abroad can in no case give rise to liability to insure, yet a person already insured who proceeds abroad for a temporary stay may nevertheless remain insured in virtue of the rule that the status of an insured person is always conserved for a year after ceasing insurable employment. Furthermore, a person already in receipt of benefit may continue to receive it with the consent of his insurance institution while he is temporarily resident abroad.

The provisions of the Norwegian law are more complete than those of the laws previously considered in that they deal with the position, not only of persons leaving the country, but also of those entering it. On the one hand insurance is compulsory for "all wage-earners employed in the Kingdom", and they continue to be so liable when sent abroad by their employers for a period not exceeding three months. On the other hand, persons for whom sick benefits are provided in connection with their employment in the Kingdom under any foreign law are exempt from the application of the Norwegian law.

SPECIAL SITUATION OF SEAMEN

One of the peculiarities of the work of seamen from the standpoint of insurance is that their place of work has no fixed relation to the national territory; the ship is sometimes in home waters, sometimes

on the high seas, and sometimes in foreign waters. How shall the liability of its crew to insurance be determined? According to an international rule which has been accepted by all maritime nations, internal matters, including insurance, affecting the crew remain subject to the regulations of the State whose flag the vessel flies, whatever its geographical position. In general this rule applies only to sea-going vessels: inland navigation and fishery, since they are carried on in home waters, are subject to the territorial principle.

Six compulsory sickness insurance laws contain provisions relating to the insurance of seamen. Of these three, viz. those of Czechoslovakia, Germany, and the Serb-Croat-Slovene Kingdom, apply to crews of national vessels without restriction as to the seamen's domicile or the routes on which the ship is engaged. The Czechoslovak law, it may be added, applies not only to maritime but to inland navigation.

The application of the British and Irish laws to seamen is not quite so broad. It is true that insurance is compulsory for persons employed as master or member of the crew of any ship registered or owned in the countries concerned, but an exception is made in the case of persons who are not domiciled and have no place of residence in the British Isles.

The Norwegian law applies the territorial principle more rigidly; for while the crews of ships navigating in territorial waters are liable to insurance, it is provided that persons who are regularly employed on foreign-going ships shall be exempt unless the voyages are limited to fixed routes and do not normally last more than 10 days out from a Norwegian port and back. Similarly, in Esthonia persons employed on long voyages are expressly excluded from the scope of sickness insurance.

The French and Belgian special schemes of seamen's insurance apply to ships flying under the national flag in any part of the world.

§ 8. — National Laws : Summary of Provisions and Statistics

AUSTRIA

Scheme applying to Commerce, Industry, Mining, and Personal Services

COMPULSORY INSURANCE

In virtue of section 1 of the codified text of the Workers' Sickness Insurance Act as promulgated by the Order of 20 November 1922, insurance is made compulsory for:

every person who is employed by way of trade as a wage-earning or salaried employee, apprentice, or domestic servant;

every person employed by way of trade simultaneously or in succession by more than one employer;
 every person employed by way of trade as home-worker, middleman or intermediary within the meaning of the Act concerning home-workers¹

Exclusion

The following persons are excluded from the scope of the Sickness Insurance Act:

persons who are included under section 1 of the Act of 13 July 1920 concerning sickness insurance for State employees and the persons excluded under section 2, subsection (1), of the said Act,
 salaried employees of provinces, unions of districts, districts, and communes, provided that they are paid by the month or the year and that they are entitled to continue to receive their salary for at least 12 months in case of sickness,
 middlemen who normally employ at least one assistant, who is not a member of their family, and further all middlemen who are members of an industrial guild which has a compulsory sickness fund for masters;
 the wife or husband of the employer;
 the children (legitimate, illegitimate or adopted), grandchildren, parents, and grandparents of

- (a) the head of an undertaking in agriculture or forestry provided that at least one worker liable to insurance is normally employed in the undertaking in addition to the said persons;
- (b) any other employer provided that the said persons are not remunerated in the same manner and degree as a worker liable to insurance;

persons who give instruction while receiving education,
 persons who are engaged only occasionally and temporarily or only as a subsidiary occupation in an occupation rendering them liable to insurance.

VOLUNTARY INSURANCE

Continued Insurance for Persons Previously Insured Compulsorily

Persons formerly subject to compulsory insurance may continue to belong to a sickness fund as long as they remain on national territory and pay the entire contribution. If they fail to pay the contribution during four successive weeks they lose their status as members and they cease to be entitled to benefits (section 13 (2)).

Voluntary Insurance for Persons outside the Scope of Compulsory Insurance

The Act of 1888 allowed persons excluded from its compulsory provisions to join the sickness funds under certain conditions. This privilege was withdrawn by the Seventh Amendment to that Act, except from persons who joined before 30 October 1921.

Scheme Applying to Agriculture

COMPULSORY INSURANCE

Compulsory insurance for agricultural workers was introduced by the Federal Act of 21 October 1921, but this Act was repealed as from 6 February 1925 as being unconstitutional. The insurance of agricultural workers is at present within the competence of the provincial legislatures only. At the present time eight out of the nine Austrian provinces have adopted sickness insurance legislation.

¹ Insurance is not compulsory for independent workers. Nevertheless, the craft guilds are entitled to establish compulsory sickness insurance schemes for their members, so that membership of guilds which have taken advantage of this power entails insurance as long as the membership lasts.

*Vienna and Lower Austria**Liability to Insurance*

The provinces of Vienna and Lower Austria have simply adopted the provisions of the Act of 21 October 1921 (Vienna Acts of 13 February and 22 May 1925; Lower Austria Act of 26 June 1925). By the terms of this legislation insurance is made compulsory for persons employed in agriculture under the conditions defined by the Workers' Sickness Insurance Act.

The following persons must become members of agricultural sickness funds

- persons employed exclusively or principally in agriculture, forestry, hunting, fishing, horticulture not carried on by way of trade, undertakings accessory to agriculture or forestry,
- persons employed as domestic servants in undertakings connected with agriculture or forestry.

Exclusion

Persons engaged in State forest undertakings are exempted from liability to insurance.

*Other Provinces**Liability to Insurance*

The laws in force in the Burgenland (7 March 1925), Carinthia (26 May 1925) Styria (20 March 1925), the Tyrol (16 December 1924), and the Vorarlberg (3 February 1925) have a very similar scope.

Exclusion

The Burgenland Act excludes from its scope the parents, collaterals, children or children-in-law of the employer, adopted children when they have been maintained without interruption by the person who employs them since the age of six and persons living in the household of the employer when they are unable by reason of physical or mental infirmity regularly to perform remunerative work (section 1).

In agricultural undertakings in which less than four workmen are permanently employed besides members of the employer's family, the employer has the option of himself undertaking the responsibility for providing the insurance benefits due in case of sickness to domestic servants not belonging to his family, when such servants live in his household and are boarded there. Domestic servants for whom the employer thus assumes responsibility are not liable to insurance. Should the employer fail to carry out this obligation, the sickness fund takes his place and provides the servant with legal benefits whilst suing the employer for the cost.

The provision concerning the exclusion of agricultural workers employed in small undertakings is not found in the Styrian Act.

The Act of 26 May 1925 which operates in Carinthia does not make insurance compulsory for agricultural workers working for an employer for less than eight days.

In the province of Salzburg an Order dated 19 January 1925 has put into operation the legislation of 6 December 1901 and 21 July 1914. This Order renders liable to insurance every person engaged solely or substantially either as a workman or as a domestic servant in an agricultural or forest undertaking or an accessory undertaking of the same character.

VOLUNTARY INSURANCE

The laws in operation in Carinthia, Salzburg, and in the Vorarlberg provide for the organisation of voluntary insurance, intended, in the case of Salzburg, for the children of persons subject to compulsory insurance and for persons who have ceased to be liable to insurance on account of unemployment, and in the case of the Vorarlberg for members of peasants' families who work for, and live with, the peasant and for persons who have given up insurable employment. The Carinthian Act limits to one year the period during which

persons who have left insurable employment may continue as voluntarily insured persons, nevertheless, the opportunity of insurance without this limitation is offered on the one hand to peasants and members of their family who work with them, and on the other hand to persons who, although agricultural workers, are excluded from the scope of insurance by reason of the fact that they are ordinarily employed for short periods.

Statistics

GENERAL AND OCCUPATIONAL STATISTICS OF THE POPULATION

Population

According to figures supplied by the Federal Statistical Office, the population of Austria in 1925 was 6,639,809, or 79 to the square kilometre.

Number of Occupied Persons

The occupied population in 1925 numbered 3,604,752, of whom 2,967,331 were employed, and 637,421 were employers and independent workers.

STATISTICS OF INSURED PERSONS

Number of Compulsorily Insured Persons

In the following table are shown both the total number of persons compulsorily and voluntarily insured during each of the last few years in virtue of the Workers' Sickness Insurance Act and similar legislation applicable to agriculture and mining.

Year	Compulsory	Voluntary	Total
1923	2,061,933	72,179	2,134,112
1924	2,178,825	65,252	2,244,077
1925	2,225,109	53,590	2,278,699

The next table shows the numbers insured under the Workers' Sickness Insurance Act only.

Year	Number of insured	Year	Number of insured
1915 . .	1,039,625	1921 . .	1,101,084
1916 . .	1,022,939	1922 . .	1,206,996
1917 . .	1,010,300	1923 . .	1,146,007
1918 . .	785,095	1924 . .	1,248,534
1919 . .	754,046	1925 . .	1,226,895
1920 . .	969,515		

It is to be noted that these totals are somewhat smaller than the real numbers because the returns of a proportion of the sickness funds arrived too late for inclusion.

The above table indicates that the number of insured persons continually diminished during the war. This decrease is to be explained by the mobilisation of successive classes of reservists. Since 1921 there has been a constant increase, save in 1923 when there was serious unemployment. The difference between the numbers insured in 1915 and 1924 is to be attributed to the bringing in of domestic servants and to the fact that many independent middle class people have had to become wage-earners.

Number of Voluntarily Insured Persons

Voluntarily insurance is of relatively small importance in Austria. The annual statistics published by the Ministry of Social Administration give the number of persons voluntarily insured during the years 1919 to 1924 as follows:

Year	Number of insured
1919	67,958
1920	75,332
1921	81,055
1922	74,374
1923	72,179
1924	65,252
1925	53,590

It is necessary to point out that the majority of voluntarily insured persons have previously been subject to compulsory insurance and have continued to belong to a sickness fund after they ceased to be liable. The number of persons entering insurance for the first time as volunteers is quite insignificant, since from 1 October 1921 onwards no new members of this class have been admitted.

Distribution of Insured Persons by Sex

The proportions of men and women respectively insured under the Workers' Sickness Insurance Act appear from the following table:

Year	Men		Women (absolute)
	Absolute	Per cent	
1915	708,292	68.1	331,333
1916	641,254	62.7	381,685
1917	663,833	59.8	406,467
1918	442,101	56.3	342,994
1919	494,071	65.5	259,975
1920	654,022	67.5	315,493
1921	756,612	68.7	344,472
1922	785,167	65.1	421,829
1923	736,101	64.2	409,906
1924	794,798	63.7	453,736
1925	773,695	63.1	453,200

The effect of the war has been to vary the proportions of the sexes, so that the percentage of men has fallen from 68.1 in 1915 to 56.3 in 1918, in which year the big public utilities, such as tramways and gas and electricity works, were largely staffed by women. It was only in 1919, after the demobilisation, that the proportion of men began to increase. In 1921 there has again occurred a reduction in the proportion of men, but this is due to the fact of bringing domestic servants into insurance.

Distribution of Insured Persons by Age

The official statistics of the Ministry of Social Administration do not indicate the distribution of insured persons by age. Nevertheless, the reports of various sickness funds do contain this information. The report of the general sickness fund of Vienna for 1924 may be taken as an example. From the statistics of this fund it appears that the most numerous age group is that of persons between the ages of 16 and 25; the subsequent groups—26 to 35, 36 to 45 and 46 to 55—diminish at an even rate, while the final groups—56 and upwards—show a rapid decrease. The following table shows the distribution by age groups and by sex of the 164,747 members of the Vienna fund in 1924.

Age groups	Men	Women	Total
14-15	3,224	2,036	5,260
16-25	26,516	17,784	45,300
26-35	20,999	11,618	32,617
36-45	16,961	7,860	24,821
46-55	14,167	4,489	18,656
56-65	7,414	1,657	9,071
66-75	2,012	403	2,415
76-85	135	35	170
86-91	6	3	9

The very rapid decrease in the number of women after the age of 25 is to be explained mainly by marriage and the consequent giving up of employment.

Number of Insured Persons' Dependants Entitled to Benefits

In virtue of section 9a (1) of the Workers' Sickness Insurance Act, the rules of a sickness fund may give its compulsorily insured members and persons who voluntarily continue compulsory insurance a claim to benefits from the fund in respect of members of their family (family insurance). Family insurance may include all benefits granted by the fund with the exception of pecuniary sick benefit. The Act proceeds to empower the Federal Minister of Social Administration to declare family insurance compulsory either generally or for particular districts.

Family insurance has not yet been established as a compulsory benefit. Nevertheless, several large sickness funds have taken advantage of the right which is conferred on them under section 9a (1). There are no statistics of the total number of dependants entitled to claim benefits, but in Part III is given the expenditure of sickness funds on family insurance.

Relation of Insured to Occupied and Total Population

- (1) Relation between insured and *total* population.

in 1925, $\frac{2,278,699}{6,639,809}$, or 34.3 per cent.,

- (2) Relation between insured and *occupied* population:

in 1925, $\frac{2,278,699}{3,604,752}$, or 63.2 per cent.;

- (3) Relation between compulsorily insured and wage-earning population.

in 1925, $\frac{2,225,109}{2,967,331}$, or 75 per cent.

BELGIUM

COMPULSORY INSURANCE OF SEAMEN

Seamen are protected against the risk of sickness either by the shipowner or by the Seamen's Benefit Fund

Duties of Shipowners

According to the Commercial Code, the shipowner is liable for the pay, medical care and repatriation of sailors and officers alike of the mercantile marine who fall ill while at sea (Commercial Code, section 109). No distinction is made between Belgians and aliens, and the provisions operate irrespective of the wages, duties or rank of the persons concerned. The nationality of the ship alone decides whether section 102 and the subsequent sections of the Code shall apply

Seamen's Benefit Fund

The persons required to contribute to the Seamen's Benefit Fund and entitled to participate in its benefits are captains, second captains, mates, petty officers, seamen, stokers, stewards, cooks, apprentices and cabin boys sailing under the Belgian flag and duly registered as members of the crew (section 2 of the rules of the Fund)

Certain classes of seamen neither contribute to, nor benefit from, the Fund, viz naval seamen, fishermen, and foreign seamen who, engaged in oversea countries for one or more intermediate voyages, to complete the crew of a Belgian ship, are discharged in an oversea port (sections 2 and 12 of the rules). These classes are covered only by the Commercial Code. It would seem also that other classes of the crew not mentioned in section 2 of the rules of the Fund, such as pursers and wireless operators, are in a similar situation

The insurance scheme of the Benefit Fund has therefore a more restricted scope than that of the Commercial Code, for while section 102 and the following sections apply to all persons sailing as seamen on Belgian ships, the Fund does not cover risks run by certain classes of seamen: fishermen, foreign sailors engaged and discharged overseas, and even certain members of the regular crew, such as pursers and wireless operators.

VOLUNTARY INSURANCE

The provisions relating to voluntary insurance are contained in Chapter VII of the rules of the Fund. Admission is open only to seamen who, being members of the Fund, remain for more than six months without employment or who are authorised to serve on a foreign ship.

Except for foreign officers unable to sail on Belgian ships by reason of the provisions of the Act of 25 August 1920 to the effect that captains and officers sailing on a Belgian ship must be of Belgian nationality, voluntary insurance may not last more than two years in the case of a seaman who is not at sea, unless he is prevented from going to sea by a duly verified sickness or unless he is specially authorised by the Managing Committee of the Fund. No limit is prescribed for the duration of voluntary membership of the Fund in the case of foreign officers who have been obliged to cease sailing on Belgian ships.

Statistics

The Belgian Mercantile Marine Department estimates the membership of the Benefit Fund at about 5,000 ¹.

BULGARIA

COMPULSORY INSURANCE

General Formula

Every wage-earning and salaried employee of a State, public, or private establishment, undertaking or estate is subject to compulsory insurance under the Social Insurance Act of 6 March 1924 (section 1)

"Wage-earning and salaried employees" mean all persons engaged for work, irrespective of sex, age, nationality, or nature of employment or remuneration (section 2).

Although the scope of the Bulgarian Act is thus defined in a general formula, yet the regulations enforcing the Act contain, by way of elucidation, a list, or rather a classification, of the occupations actually comprised within the formula. It may be observed that this list includes:

agriculture, forest industries, fishery;
sanatoria, hospitals, pharmacies, artistic and photographic studios, cinematographs, technical offices and other liberal professions;
public and private boarding-houses, orphanages, benevolent institutions, sporting clubs, political and economic societies, and learned societies; and households employing servants, coachmen and grooms. (Regulations, para. 7)

Foreign Undertakings

The branches of foreign undertakings are subject to the Act, whether the workers employed are foreigners or not (Regulations, para. 5).

¹ The International Labour Office possesses no information as to the number and the composition of the seafaring population, the occupied portion of which constitutes the majority of the membership of the Fund

*Exclusion and Exemption**Seasonal Workers*

In virtue of regulations made under section 1, note II, of the Act, certain kinds of seasonal occupations are excluded from compulsory insurance, viz. mowers, reapers, vine-dressers, rose-pickers, and wood-cutters, and so likewise are temporary building workers and diggers (Regulations, paras. 13 and 21).

Employer's Family

The wife (husband), ascendants and minor descendants of the employer are not considered as insurable wage-earners (Regulations, para 9)

Public Servants

Persons who are liable to deduction from their pay under any Pension Act are excluded from insurance. Nevertheless, wage-earning employees of State undertakings who are covered by the Pension Act for the staff of institutions belonging to the State and local authorities may be brought under the Social Insurance Act if the benefits for workers provided therein are more advantageous to them (section 1, note III).

VOLUNTARY INSURANCE

Independent handicraft workers, persons engaged in commerce, farmers, and members of the liberal professions whose annual income is not more than 50,000 leva, and likewise officials of institutions belonging to the State and local authorities may insure voluntarily (section 1, note III).

If the income of a voluntarily insured person exceeds the above-mentioned limit, his sickness insurance ceases (Regulations, para 18).

Statistics ¹

GENERAL AND OCCUPATIONAL STATISTICS OF THE POPULATION

Population

In 1925, the population of Bulgaria numbered 5,081,700.

The average density of the population was 48.5 inhabitants per square kilometre.

The urban population constituted 20 per cent of the total, and the rural population 80 per cent.

Number of Occupied Persons

The occupied portion of the population in 1925 numbered 2,761,651, or 54 per cent. of the total

Number of Employed Persons

According to an enquiry undertaken at the end of 1925 the number of persons ordinarily engaged in non-agricultural employment, whether actually employed or not was 387,061, or 7.7 per cent of the population. The total number of employed persons, including agricultural workers, in 1925, was 427,994, or 8.4 per cent of the population

STATISTICS OF INSURED PERSONS

Number of Insured Persons

The number of men and women wage-earners compulsorily insured against sickness is shown in the following table, from which it is apparent that the

¹ All the figures given here were supplied to the International Labour Office by the Bulgarian Government.

number has grown rapidly, especially since the scope was enlarged by the Act of 1924.

Year	Number of insured	
	Absolute	Index number
1919	34,720	100
1920	62,864	180
1921	97,564	252
1922	112,242	323
1923	125,680	362
1924	167,820	483
1925	241,143	695

Relation of Insured to Occupied and Total Population

- (1) Relation of insured to occupied population:

$$\frac{241,143}{2,761,651} \text{ or } 9 \text{ per cent.}$$

- (2) Relation of insured to employed population:

$$\frac{241,143}{427,994} \text{ or } 56 \text{ per cent.}$$

- (3) Relation of insured to total population:

$$\frac{241,143}{5,081,700} \text{ or } 4.8 \text{ per cent.}$$

CZECHOSLOVAKIA

COMPULSORY INSURANCE

General Formula

The Czechoslovak Act of 9 October 1924 makes insurance compulsory for every person who performs work or renders services in the Republic under an agreement for work, service or apprenticeship (as an improver or probationer) and not by way of subsidiary or occasional employment (section 2 (2)).

The scope of the Act also covers workers engaged in inland or marine navigation even if permanently employed outside the territory of the Republic, and also citizens rendering their statutory military service, provided that they were previously liable to insurance or enter insurable employment not more than six months after their discharge (section 2 (2) and (3)).

Home Workers

Home workers are liable to insurance, provided that, without being owners of industrial undertakings, they perform industrial work by way of trade on account of one or more employers (section 3). In order that home work should entail liability, it is required that the work should not be occasional, but it is immaterial if the work is subsidiary.

Power is taken in the Act to extend insurance to owners of industrial undertakings who are engaged in home work even if they work for private customers as well as for one or more employers (section 4 (1)). No action has yet been taken under this provision.

Miners

Insurance is also compulsory for miners in virtue of the Act of 11 July 1922 concerning insurance in miners' benefit societies

Exclusion

Exclusion from compulsory sickness insurance is prescribed in the case of foreign salaried employees of official representatives of foreign countries in the Republic and of international commissions.

Further, on the ground of equivalent treatment, liability to insurance is not imposed upon employees of the State and other compulsory territorial associations (for provinces, counties, etc.), or of bodies corporate declared by the Ministry of Social Welfare, in agreement with other Ministries concerned, to be of similar character, and likewise salaried employees of their institutions and undertakings, including salaried employees of railways, provided that in case of sickness they are entitled to their salary for at least a year or to benefits at least equal to those under the Act of 9 October 1924.

VOLUNTARY INSURANCE

Continued Insurance for Persons previously Insured Compulsorily

Any person who, having been compulsorily insured for at least three months, leaves insurable employment and does not enter another such employment is entitled to continue insurance voluntarily with the sickness insurance institution with which he was last compulsorily insured. Insurance is continued in the wage-class to which the person belonged on leaving employment or in a lower class (section 250 (1)).

This insurance begins on the day on which the insurance institution receives the application of the person desiring to continue his insurance. The application must however be made within four weeks of leaving employment. If the duration of the last employment was less than four weeks, the period of grace does not exceed such duration (section 250 (3)).

The insurance lapses if the person leaves the territory of the Republic, or if the contribution is four weeks in arrears (section 250 (4)).

Voluntary Insurance for Persons outside the Scope of Compulsory Insurance

District and agricultural insurance institutions may also insure against sickness persons not liable under the compulsory provisions of the Act of 9 October 1924. Persons can only be insured in certain wage-classes (classes III to V) and under conditions to be prescribed by the rules of the institutions. An entrance fee of six weeks' contributions must be paid. A claim to sick benefit is not entertained till the end of a time limit specified in the rules, which shall not be less than four weeks or more than eight weeks, provided that no claim may be made on account of sickness, pregnancy or confinement, if the person concerned was sick or pregnant at the date of affiliation (section 251).

Statistics

Sickness insurance was introduced in Czechoslovakia in 1888, when it applied to wage-earners in industrial and commercial undertakings. The Act of 15 May 1919 made insurance compulsory for agricultural workers also so that even before the Act of 9 October 1924 the vast majority of wage-earners were made liable to insurance. The insurance statistics reproduced below refer to the regime previous to the coming into force of the 1924 Act.

GENERAL AND OCCUPATIONAL STATISTICS OF THE POPULATION

Population

The total population of Czechoslovakia as shown by the Census of 1921 and its subsequent movement are indicated by the following figures:

1921	13,599,133	1923	13,841,321
1922	13,722,892	1924	13,985,890

Number of Occupied Persons

The numbers of occupied persons and wage-earners respectively, including domestic servants but not dependants of the employer, have been as follows in the last few years

Year	Occupied	Wage-earning
1921	6,053,193	3,908,119
1922	6,110,167	3,944,903
1923	6,162,898	3,978,948
1924	6,227,145	4,020,428

STATISTICS OF INSURED PERSONS

Number of Insured Persons

Statistics have been collected separately for Bohemia, Moravia and Silesia on the one hand, and for Slovakia and Sub-Carpathian Russia on the other. The following figures show the average annual numbers of insured persons in these two regions, the total number and the distribution between compulsory and voluntary insurance:

Year	Bohemia, Moravia, Silesia	Slovakia, Sub-Carpathian Russia	Total insured	Compulsory ¹	Voluntary
1921	2,029,576	311,115	2,340,691	2,249,978	90,713
1922	2,136,547	306,910	2,443,457	2,328,704	114,753
1923	2,168,473	306,730	2,475,203	2,415,409	59,794
1924	2,362,119	329,628	2,691,747	2,635,092	56,655

¹ Including the small number of persons voluntarily insured in Slovakia and Sub-Carpathian Russia.

Relation of Insured to Occupied and Total Population

In 1924 the insured represented

19.25 per cent of the total population.

43.23 per cent of the occupied population

The ratio of the compulsorily insured to the wage-earning population in 1924 was 65.54 per cent.

ESTHONIA

COMPULSORY INSURANCE

The Estonian law, which is incorporated in the Industrial Labour Code, defines its scope by enumerating the kinds of undertakings to which it applies.

In accordance with section 257, the law covers industrial undertakings, small masters, mines, inland navigation (rivers, canals, inland seas, and lakes), tramways, and building, but does not apply to any undertaking employing less than five workers. The insurance authorities, however, may make insurance compulsory for industrial undertakings which employ less than five workers.

Municipal undertakings also come within the scope of compulsory sickness insurance (section 258).

Workers in certain State undertakings have been brought within the scheme by a series of special Acts: (1) schist quarries (Act of 19 June 1922), (2) peat diggings (Act of 27 June 1922), and (3) State printing (Act of 7 March 1923).

All workers in the undertakings to which the law applies are liable to insurance irrespective of age or sex, provided that they are employed for remuneration (section 260).

Insurance is also compulsory for persons employed by sickness funds (section 261 (1)), and for aliens. Rules are to be laid down by the Workers' Insurance Council determining the conditions under which insurance will become applicable to persons working in co-operative undertakings (artels) (section 262).

Exclusion and Exemption

The law fails to cover agriculture, the mercantile marine, commerce, domestic servants, home workers, and industrial undertakings employing less than five persons.

State undertakings other than those brought within the scope of insurance by the special laws mentioned above are expressly excluded and so also are always of public utility (section 259), but the workers concerned are provided with gratuitous benefits, both in cash and in kind, at least as valuable as those of the general scheme.

Exemption from liability to insurance may be granted in the two following cases

(1) The workers' insurance authorities may in exceptional cases, when special circumstances make it difficult to combine one isolated undertaking having less than 500 workers with another undertaking for the purpose of forming a sickness fund, exempt such undertaking from the scope of the law until the difficulty has been overcome (section 270 (1))

(2) The workers' insurance authorities may exempt from insurance any undertaking having a temporary character

Casual Workers

It is provided that casual workers employed on jobs the duration of which does not exceed one week shall be excluded from insurance (section 260).

Unpaid Apprentices

The question of unpaid apprentices is not dealt with in the Act. Nevertheless, it may be inferred that an apprentice who receives no wages either in money or in kind would not be entitled to insurance benefits, since there exists no basis for calculating them. In practice, however, in view of the scarcity of apprentices, it is usual to begin paying them after a short period of probation which, on the average, does not exceed two or three months.

Statistics ¹

GENERAL AND OCCUPATIONAL STATISTICS OF THE POPULATION

The following table, compiled from the Census of 28 December 1922, shows how the occupied classes are related to the total population:

Total population	Number of persons regularly engaged in gainful occupations	Number of employed persons	Number of employers and persons working on their own account
1,107,059	392,039	229,642	162,397
Per cent 100	Per cent 35.4	Per cent 20.1	Per cent 16.1

STATISTICS OF INSURED PERSONS

Number of Insured Persons

The following table shows the average monthly number for each year of insured persons and their dependants

¹ All the figures given here were supplied to the International Labour Office by the Ethiopian Government

Year	Number of insured persons			Number of insured persons' dependants
	Total	Men	Women	
1919	12,047	6,851	5,196	—
1920	14,401	9,079	5,322	—
1921	19,050	12,775	6,275	21,437
1922	25,483	17,550	7,933	29,422
1923	33,991	22,847	11,144	37,259
1924	33,561	22,972	10,589	39,581

Distribution of Insured Persons by Occupation

The distribution of insured persons among the various branches of industry is indicated in the following table.

Year	Mining	Stone and earth	Metal	Chemical	Gas and electricity	Textile	Wood	Hides and skins	Paper	Food
1923	2,810	631	4,403	1,282	587	9,736	4,565	915	2,475	1,896
1924	2,939	748	3,423	1,568	649	8,765	3,962	789	2,422	1,987
	%	%	%	%	%	%	%	%	%	%
1923	8.2	1.8	12.8	3.7	1.7	28.3	13.2	2.7	7.2	5.5
1924	9.0	2.3	10.4	4.8	2.0	26.7	12.1	2.4	7.4	6.1

Year	Drink and spices	Clothing	Building	Printing	Cleaning	Commerce	Transport and communications	Other	Unknown	Total
1923	1,441	1,070	399	1,364	123	238	455	—	—	34,390
1924	1,438	1,178	589	1,431	132	194	512	41	794	33,561
	%	%	%	%	%	%	%	%	%	%
1923	4.2	3.1	1.2	4.0	0.4	0.7	1.3	—	—	100
1924	4.4	3.6	1.8	4.4	0.4	0.6	1.5	0.1	2.4	100

Relation of Insured to Occupied and Total Population

The insured population represented in 1924—

3.03	per cent.	of the total	population in 1922
8.79	„ „ „	occupied	„ „
14.62	„ „ „	employed	„ „

FRANCE

General Scheme for Alsace-Lorraine

COMPULSORY INSURANCE

The insurance system in operation in Alsace-Lorraine has its legal foundation in sections 3 and 4 of the Act of 17 October 1919, which prescribes that the territories restored to French sovereignty continue to be governed by the provisions in force at the time of the promulgation of the Act until special legislation has been passed introducing measures applicable in the rest of the country. Local legislation for Alsace-Lorraine is effected by means of Decrees, which must be ratified by the Parliament within one month.

The system established by the German Federal Insurance Code is therefore maintained in force in Alsace-Lorraine, and the Act of 1 June 1924, introducing civil legislation in the Departments of the Lower and Upper Rhine and the Moselle has, by section 7, par 3, confirmed this state of affairs.

The Act of 24 July 1925 relating to the administrative system of these three Departments has made no change in the matter of social insurance.

It would therefore seem useless under these conditions to describe anew the scope of the Federal Insurance Code which is already analysed in the section on German legislation (see p. 87). It will be sufficient to notice the modifications introduced by French law.

General Formula

No change has been made in the general formula of section 165 of the Insurance Code, defining the scope of insurance.

Exclusion and Exemption

The exclusions or exemptions from liability to insurance provided, either in the Code itself or, in the case of temporary or occasional workers, by the Decree of 17 November 1913 have been maintained in their entirety. Nevertheless, the maximum income limit only applies to salaried employees, foremen, and other persons of similar status. Contrary to the provisions in force on this matter in Germany, craftsmen working in their homes are subject to insurance, irrespective of their income.

The income limit was fixed at 10,000 francs a year by the Decree of 28 December 1925.

The following classes of workers are exempt from liability to insure on grounds arising out of the provisions of French legislation:

(1) Civil servants covered by the Act of 9 June 1853 on civil pensions and its amending Acts as well as employees appointed or recruited for local administration, when they are covered by a scheme identical with that prescribed by section 16 of the Decree of 9 November 1853, which regulates the operation of the Act of 9 June 1853 (Decree of 14 May 1924).

(2) Post and telegraph workers covered by the provisions of the Ministerial Decree of 26 April 1902 concerning sick leave (Decree of 28 December 1924).

(3) The staff of Alsace-Lorraine railways. The Act of 30 December 1923, whereby the superannuation scheme for railwaymen on other great lines was applied to the staff of these railways repealed all the provisions of Book II of the Insurance Code relating to sickness insurance (section 11). Nevertheless, the old sickness fund to which the railwaymen of Alsace-Lorraine are compulsorily affiliated has been maintained, although it has its own rules. This fund henceforward provides gratuitously the same benefits as those which are granted to the staff of other French railway systems and in return for a contribution it provides for its members those benefits prescribed under the former regime which, according to French law, are not to be supplied at the expense of the railway.

VOLUNTARY INSURANCE

The voluntary continuation of compulsory insurance and admission to voluntary insurance are effected under conditions prescribed by the Federal Insurance Code, the provisions of which have not been modified.

The French legislation, unlike that of Germany, has retained the minimum income limit beyond which voluntarily insured persons are excluded from insurance. a person whose income does not exceed 10,000 francs a year cannot insure voluntarily; moreover a person whose income is found by the management of the sickness fund regularly to exceed 15,000 francs a year cannot continue in voluntary insurance (sections 176 and 178 of the Federal Insurance Code, Decree of 21 December 1925).

Statistics

GENERAL AND OCCUPATIONAL STATISTICS OF THE POPULATION

Population

According to the results of the Census of 1921, the legal population on 6 March 1921 numbered 1,709,000 inhabitants while the population present in the area was estimated at 1,695,123, of whom 845,607 were men and 849,516 were women. The Census of 1926 showed a population of 1,795,000.

Occupied Population

The results of the Census of 1921 concerning the occupied population in Alsace-Lorraine have been published in the statistical returns of these two provinces (*Publication de la Direction du Travail, Haut-Commissariat général de la République*). At that date the occupied population consisted of

876,799 persons or 51.72 per cent. of the population present in the area; of whom 583,875 were men, being 96 per cent. of the male population between the ages of 15 and 70, and 292,924 were women, being 50 per cent. of the female population between the same ages.

DISTRIBUTION OF THE WAGE-EARNING POPULATION BY OCCUPATIONS

The following data concerning the occupations of wage-earners and salaried employees are taken from the Census of 1921:

Occupation	Non-manual		Manual		Total	Per cent. of occupied population
	Men	Women	Men	Women		
Agriculture and forestry	24	14	63,641	58,141	121,820	13.89
Extractive industries	1,515	77	38,533	176	40,331	4.60
Transformative industries	15,461	4,201	117,076	48,645	215,386 ¹	24.66
Handling and transport	8,131	407	39,334	543	48,415	5.52
Commerce and banks	13,922	15,203	8,122	2,440	39,687	4.53
Liberal professions	5,176	7,837	1,200	1,556	15,769	1.80
Personal services	983	178	1,860	18,749	21,770	2.48
Public services	58,273	7,109	22,442	1,816	89,640	10.22

¹ Including 28,300 manual and non-manual workers in the metal industry and 61,500 in the textile industry.

The total number of inhabitants comprised in this table is 592,818. the difference between this number and that of the total occupied population represents employers, the unemployed and persons working on their own account, the last being mainly those engaged in the liberal professions.

STATISTICS OF INSURED PERSONS

Number of Insured Persons

The following table gives for each year from 1919 to 1923 the total number of insured persons and the proportion compulsorily and voluntarily insured. Each annual figure is an average of the average monthly membership.

Year	Number of insured				
	Compulsory		Voluntary		Total
	Absolute	Per cent. of total insured	Absolute	Per cent. of total insured	
1919	348,292	93.2	23,092	6.8	341,384
1920	362,937	94.2	22,369	5.8	385,306
1921	365,951	93.6	25,030	6.4	390,981
1922	385,719	93.3	27,664	6.7	413,383
1923	408,933	93.1	30,126	6.9	439,059

From 1919 to 1920 an increase of 13 per cent took place in the number of insured persons. The increase was greater for the Upper Rhine than for the other Departments, and was due mainly to the rise in the number of women insured. At the same time a decrease was noticeable in the number of women who were voluntarily insured.

In 1921 the unemployment crisis which occurred towards the middle of the year, especially in the textile and metal industries, resulted in a decrease in the number of persons insured with establishment funds in general and with the local funds of the Lower Rhine. Nevertheless, on the whole, the average number of insured persons increased 1.5 per cent upon the 1920 figure. The number of voluntarily insured members increased 12 per cent. upon the number in the previous year. Voluntary insurance continued to be more favoured by women.

In 1922 the increase in the total number of insured upon that of the previous year was 5.7 per cent. This increase must be attributed to a notable improvement in the employment situation. The proportion of women continued to grow on the whole, although it diminished in voluntary insurance. The number of voluntary members showed a marked increase.

The rise in the number of insured persons from 1922 to 1923 represented 6.2 per cent. There was a general improvement in business, the result of which was to swell the membership of the local funds. The rate of increase in the number of voluntary members nevertheless diminished (12 per cent from 1920 to 1921; 10 per cent from 1921 to 1922; 9 per cent from 1922 to 1923). The larger proportion of the voluntary membership continued to be recorded among the female population.

There were in 1921 89,640 civil servants entitled to benefits equivalent to those provided by compulsory insurance.

Distribution of Insured Persons by Sex

In the next table, which shows the distribution of insured persons by sex and which distinguishes between compulsory and voluntary insurance, it will be observed that voluntary members are recruited in a stronger proportion from women than from men. This appears to be the consequence of two causes. The first is that the proportion of persons compulsorily insured to the total number of persons insured, or having the right to insure voluntarily, is much stronger in the case of men than in the case of women. The second is that insurance offers a greater attraction to women than to men.

Year	Compulsory				Voluntary			
	Men		Women		Men		Women	
	Absolute	Per cent. of total insured	Absolute	Per cent. of total insured	Absolute	Per cent. of total insured	Absolute	Per cent. of total insured
1919	242,633	76.2	75,659	23.8	8,909	38.6	14,183	60.4
1920	270,497	74.5	92,440	25.5	9,112	40.7	13,257	59.3
1921	270,155	73.8	95,796	26.2	10,503	42.0	14,527	58.0
1922	281,236	72.9	104,483	27.1	12,048	43.5	15,616	56.5
1923	297,588	72.8	111,345	27.2	12,890	42.8	17,236	57.2

Number of Apprentices

The last table shows the number of unpaid apprentices who are insured.

Year	Male	Female	Total	Per cent. of average number compulsorily insured
1919	2,498	1,647	4,145	1.3
1920	3,082	1,659	4,741	1.3
1921	3,636	2,030	5,666	1.5
1922	4,495	2,452	6,947	1.8
1923	5,089	2,486	7,575	1.9

Relation of Insured to Occupied and Total Population

Relation of insured to total population in 1921:

$$\frac{\text{Insured population } 390,981}{\text{Total population } 1,709,000} = 22.9 \text{ per cent.}$$

Relation of insured to occupied population:

$$\frac{\text{Insured population } 390,981}{\text{Occupied population } 876,799} = 44.6 \text{ per cent.}$$

Relation between compulsorily insured and wage-earning population:

$$\frac{\text{Compulsorily insured } 365,951}{\text{Wage-earning popul } 592,818} = 61.73 \text{ per cent.}$$

Special Scheme for Miners

COMPULSORY INSURANCE

The scope of the scheme is defined, on the one hand, by the nature of the industry, and, on the other, by the conditions of employment of persons engaged in this industry.

Industries Covered

The industries covered are, in principle, all mining undertakings (Act of 29 June 1894, section 1); that is to say, mines opened in conceded mine-fields.

The Act of 1894 provides, moreover, in section 6 that the industries attached

to mining undertakings may, on the application of the parties concerned and with the authorisation of the Ministry of Labour, be included among the industries to which the insurance scheme applies.

This extension of the scope was therefore at first voluntary, but the Act of 28 December 1923 introduced an important amendment on this point. In virtue of section 1 of this Act, an order of the Ministers of Labour and of Public Works may extend, either obligatorily or on the application of the parties concerned, the miners' sickness insurance scheme to industrial undertakings managed by mine-owners, if such establishments obtain their raw material ordinarily and mainly from the mine and if the work accessory to the operation of the mine is carried out on the conceded area or in a neighbouring region. It is to be observed that these decisions, whereby other industries are assimilated to mines, apply to individual cases only, and that they become inoperative if the subsidiary industry is ceded to a third party.

Moreover quarries may be assimilated, for the purpose of the application of the insurance scheme, to mining undertakings in virtue of Decrees of the Council of State on the recommendation of the Minister of Labour (Act of 1894, section 31).

Lastly, the Decree of 11 February 1920 has assimilated to mining undertakings slate quarries, the size or method of working of which justifies such assimilation. Decisions taken by the Minister of Labour, after consultation with the Minister of Public Works and the Permanent Section of the Consultative Committee on Mines, specify the undertakings affected by this assimilation.

Persons Covered

The persons covered are workmen and salaried employees in the industries covered without any limit of wages or salary (Act of 1894, section 1).

By workmen in mining undertakings properly so-called is to be understood in the first place the underground workers, and then those surface workers engaged in accessory operations which are legally attached to the work of extraction properly so-called, or are carried out in places, workshops or yards which are legal dependencies of the mine according to mining law (Ministerial Circular of 30 June 1924).

Further, the term "salaried employee" means all salaried employees without distinction of grade from the chief engineer down to the least of the supervisors. Nevertheless, among the Office workers only those are included whose occupation or place of work attaches them directly to the place on which the actual mining or the accessory work assimilated thereto is carried out (Ministerial Circular of 30 June 1924).

Moreover, the safety delegates of the miners who work in the mine where they perform their office remain insured for the duration of their office (Act of 2 April 1906, sections 3 and 5).

The members of the family of insured persons can in no case become members of benefit funds, although, if the rules of the fund so provide (see below "benefits"), they may receive cash benefit, medical attention and medicines.

VOLUNTARY INSURANCE

A complementary scheme of voluntary insurance is set up for workers in subsidiary industries and for the safety delegates of miners who do not work in the mine.

Workmen and salaried employees who have formerly worked in a subsidiary industry assimilated to a mining undertaking, and who are now engaged in an undertaking of the same character which is not assimilated, may be authorised by the Minister of Labour to continue to be covered by the provisions of the Act of 29 January 1894 in the matter of sickness insurance (Act of 28 December 1925, section 2). In the same way, if an assimilated subsidiary industry is ceded to a third party whereby the order of assimilation ceases to be operative, the workman may, under the same conditions, continue to be insured against sickness, provided that the undertaking continues within the area of the concession or in the neighbouring region.

Every safety delegate of the miners who is not at present working in the mine or who is no longer working in any mine may be insured at his request (Act of 2 April 1906, sections 3 and 4, and Decree of 28 December 1906, sections 5 and 6)

Statistics

The International Labour Office possesses no information concerning the number and composition of the population dependent on the mining industry, the occupied portion of which forms the mass of the persons insured.

The *Statistique de l'Industrie minière*, from which are taken the data shown below, gives the number of workmen employed in mines (first table) and the number of workmen insured (second table), but one cannot determine exactly the discrepancy between the actual and the theoretical scopes by comparing these numbers. The number of workmen shown in the first table includes the miners, but it does not include men employed in subsidiary industries or in assimilated quarries, the workmen of which are insured and, as such, are included in the second table. One may note, moreover, that the number of workmen insured is sometimes higher than that of the workmen shown in the first table, which fact suffices to show that a comparison between the two tables is valueless.

WORKMEN IN MINES (NOT INCLUDING SUBSIDIARY INDUSTRIES OR MINES OF ALSACE AND LORRAINE)¹

Year	Workmen	Index number base = 1913
1913	237,864	100
1919	168,233	70.7
1920	203,963	85.7
1921	212,457	89.3
1922	221,029	92.9
1923	256,042	107.6

¹ Each volume of the *Statistique de l'Industrie minière* contains a general table showing for each department the number of workmen employed in mines. The numbers shown in the above table have been obtained for the years 1919 onwards by subtracting from the total for all departments the figures for the departments of the Moselle and Lower and Upper Rhine, where the mining workmen are covered by the special insurance scheme for Alsace-Lorraine.

MEMBERSHIP OF BENEFIT FUNDS

Year	Workmen	Salaried employees	Total	Index number base = 1913
1913	233,386	9,508	242,894	100
1919	176,879	5,923	182,802	75.3
1920	192,017	2,059	201,076	82.8
1921	214,096	10,151	224,247	92.3
1922	228,807	11,249	240,056	98.8
1923	254,535	11,097	265,232	109.2

The *Statistique de l'Industrie minière* gives for each year a distribution of workmen among the following classes: men over the age of 18, young persons between the ages of 16 and 18, children under 16 and women over 18. The group of young persons from 16 to 18 and of children under 16 includes both girls and boys. This distribution is shown below (it does not cover subsidiary industries, or Alsace-Lorraine).

DISTRIBUTION BY AGE AND SEX OF MINING WORKERS¹

Year	Men	Young Persons	Children under 16	Women	Total
1913	199,501 (839)	14,900 (63)	19,050 (80)	4,413 (18)	237,864
1919	143,352 (852)	11,281 (67)	18,828 (52)	4,772 (29)	168,233
1920	174,252 (854)	12,591 (62)	11,927 (58)	5,193 (26)	203,963
1921	180,275 (848)	12,865 (61)	14,369 (68)	4,948 (23)	212,457
1922	188,594 (853)	12,643 (57)	14,998 (68)	4,794 (22)	221,029
1923	220,332 (860)	14,018 (55)	16,608 (65)	5,084 (20)	256,042

¹ The numbers in parentheses indicate the proportion per 1,000

Further, there exist statistics for the year 1911 of the age distribution which were drawn up in the course of an enquiry on pensions for miners carried out by the Central Mining Committee of France and the Ministry of Labour and Social Welfare¹

The following table reproduces from that source the age distribution of workmen and salaried employees engaged in mines who acquire the right to old-age pensions or more exactly the number of such workmen who attain each age in the course of the year. As, theoretically, the scope of superannuation insurance is the same as that of sickness insurance, one thus obtains statistics of the age distribution of members of sickness benefit funds at the same time. The total number of persons covered by the enquiry was 225,356. In the same year the *Statistique de l'Industrie minière* shows the membership for sickness benefit funds to be 237,937

AGE DISTRIBUTION IN 1911 OF WORKMEN AND SALARIED EMPLOYEES IN MINES ACQUIRING THE RIGHT TO OLD-AGE PENSIONS

Age reached in the course of the year	Number of persons	Age reached in the course of the year	Number of persons	Age reached in the course of the year	Number of persons
Years		Years		Years	
13	4,804	31	6,253	49	3,051
14	6,034	32	6,441	50	2,823
15	6,370	33	6,165	51	2,598
16	6,613	34	6,320	52	2,622
17	6,794	35	6,428	53	2,348
18	7,497	36	6,391	54	2,072
19	7,193	37	6,004	55	1,421
20	7,111	38	5,590	56	1,037
21	2,613	39	5,530	57	875
22	1,977	40	4,601	58	807
23	5,653	41	4,635	59	727
24	6,471	42	4,504	60	620
25	6,640	43	4,204	61	487
26	6,775	44	4,111	62	424
27	7,091	45	4,179	63	301
28	6,734	46	3,714	64	310
29	6,708	47	3,726		
30	6,581	48	3,489	and 65 over	884

¹ COMITE CENTRAL DES HOUILLERES DE FRANCE. *Retraites des Mineurs*. Paris 1912.

Special Scheme for Seamen

Duties of Shipowners

The Commercial Code makes shipowners liable for the wages, nursing and treatment of seamen who fall ill while at sea or who are injured in the service of the ship (section 262).

The beneficiaries of these provisions are registered wage-earning seamen, not being officers, employed on French sea-going ships, including pleasure vessels.

Section 272, however, of the Commercial Code extends to the whole crew, including unregistered seamen engaged for the purposes of work, the protection of section 262.

Nevertheless, according to an opinion given by the Disputes Committee of the Mercantile Marine, the section just quoted does not apply to the foreign seamen regularly engaged on a French merchant ship unless there exists a special convention guaranteeing diplomatic reciprocity in the matter of the insurance of sailors¹ (Ministerial Circular of 29 June 1911).

Lastly, the principle has been legally established that no distinction arising out of the method of engagement could be made between seamen for the purpose of the application of section 262²

Seamen's Benefit Fund

In accordance with the first section of the Act of 29 December 1905, membership of the Benefit Fund is made compulsory for the following classes and for them only.

- (a) all registered seamen from the time of their registration which, according to section 29 of the Act of 17 April 1907, cannot take place under the age of 13 (or 12 if the person concerned receives a certificate of primary education),
- (b) unregistered crew employed on French sea-going ships other than warships and ships engaged solely in the public service

Limits of the General Formula and Conditions of Admission to Insurance

Conditions to be fulfilled by Persons

(a) The category of registered seamen includes not only those registered in France but those of Algeria, Martinique, Guadeloupe, Réunion, Guiana, Islands of St. Pierre and Miquelon, and all other colonies where registration can be legally effected (Act of 1905, section 30)

(b) Unregistered members of the crew of either sex include wage-earners, being French subjects, whose names appear on the list of the crew of the ship. This list is drawn up by an official of the port where the vessel is registered in accordance with the following rule. All persons receiving an ordinary wage and carrying out on board work which is necessary for the sailing of the ship must be included in the crew. Such are the officers commanding the ship, doctors, pursers, accountants, housekeepers, cashiers, stewards, cooks, domestic servants, supercargoes³, engineers, electricians, telegraphists, etc. On the other hand, purveyors, hairdressers, musicians, etc., and, in general, all persons working on their own account are not included in the crew (Ministerial Instruction of 20 April 1906, sections 3-9).

(c) Foreigners may in no case belong to the Benefit Fund (Ministerial Instruction of 20 April 1906, section 15).

Conditions to be Fulfilled by the Ship

(a) For registered seamen the fact of being registered without other condition is sufficient in itself to cause them to be members of the Benefit

¹ Franco-British Convention of 5 November 1879, and Franco-Italian Convention of 1 January 1882.

² Note decision of the Court of Cassation of 17 February 1872

³ Agents of the shipowner whose duty is to manage the cargo.

Fund. It must, however, be pointed out that the obligation to contribute and the title to benefit depend upon a variety of conditions arising out of the nature of the ship and its voyages (see below contributions and benefits).

(b) For the unregistered crew, membership of the Fund arises provided that the ship is:

- (1) French;
- (2) sea-going;
- (3) neither a warship nor a ship employed solely in the public service. The last category includes ships which belong to various departments of the State, Chambers of Commerce, and municipalities and which are used in the working of these establishments (Ministerial Instruction of 20 April 1906, section 12).

Statistics ¹

Year	Membership of the Benefit Fund	
	Registered seamen	Unregistered seamen
1913	126,918	7,544
1919	100,232	7,744
1920	131,130	9,639
1921	131,544	10,292
1922	126,177	10,175
1923	122,567	11,935
1924	119,703	12,345

GERMANY

COMPULSORY INSURANCE

General Formula

Section 165 of the Federal Insurance Code renders the following classes of persons liable to compulsory insurance

- (1) Wage-earning workers, including the crews of ships engaged in inland navigation, and seamen, when they are not covered by sections 59 to 62 of the Seamen's Code, and Articles 553 to 553(b) of the Commercial Code.
- (2) Apprentices, whether remunerated or not
- (3) Persons engaged in home industry at the order and for the account of other persons engaged in industry.

Manual workers and apprentices are, with the exception of foremen and persons in a similar superior position, compulsorily insured on the sole condition that they are employed for remuneration.

Exclusion and Exemption

Income Limit

Not all wage-earners, however, are liable to insurance. The first restriction is an income limit. Non-manual workers and persons engaged in manual work on their own account, as well as foremen and persons in a similar superior position, are excluded from the scope of insurance when their annual earnings, after deduction of family allowances, exceed a limit prescribed by the Federal

¹ The International Labour Office possesses no information as to the number and composition of the sea-faring population, the occupied portion of which constitutes the majority of the members of the Fund.

Minister of Labour (section 165, second paragraph, and section 165 (b)). The same rule applies to those few ships' captains who are not protected by the Commercial Code. At the present time the limit is fixed at 3,600 marks a year (Order of 15 July 1927).

Occasional Workers

Wage-earning work must be the principal means of livelihood. In order to give rise to liability to insurance, the work must not be of an occasional or subsidiary character (section 168 and Decree of 17 November 1913).

The following are to be considered as occasional employments:

- employment for not more than three days of persons who, working ordinarily for remuneration, are passing through a period of unemployment.
- employment for less than a week of persons not ordinarily engaged in paid work,
- services rendered in emergencies (accidents and calamities), provided that the duration of such service is not likely to exceed three days;
- occupation on German territory of the staff of foreign railway companies;
- temporary occupation on German territory of the crews of foreign ships;
- employment of school children in seasonal agricultural work, as long as such work does not exceed either eight weeks or forty days, according as the work is or is not distributed over several periods of the year.

Subsidiary Occupations

A subsidiary occupation is one which, whether or not usually performed by persons who do not work for wages, only entails a very small remuneration: an occupation which covers more than one-third of the working day, and entails a remuneration of more than one-third of the ordinary daily wage in the locality, cannot be regarded as subsidiary.

A secondary occupation performed while the person concerned is already working elsewhere under a regular contract of service does not imply liability to insurance, even if the principal occupation is one which is excepted from the scope of insurance.

Equivalent Treatment

Persons entitled by the terms of their employment to benefits equivalent to those provided by the sickness funds are excepted. This provision applies to officials, medical practitioners and dentists employed in the service of the Federation, the German Federal Railway Company, a State, a Federation of Communes, a Commune, an insurance carrier, or a public body, and also to all persons employed by the employers just mentioned who are appointed for life or under State law, without liability to recall, or with a right to a superannuation allowance (sections 169 and 170). Teachers, doctors and dentists in the service of private institutions which guarantee to them benefits equivalent to those provided by sickness funds may, on the application of their employers, be exempted from insurance either entirely or partially (section 171).

Exemption on Account of Occupation

Exemption from insurance is also prescribed in the case of persons (other than apprentices) who work for remuneration in the course of their scientific training for their future occupation, and persons who, from predominantly religious or ethical motives, are engaged in sick nursing, education, or other services to the public, and receive no more than free maintenance or a small remuneration which is no more than sufficient to procure the absolute necessities of life (section 172).

On the application of their employers, exemption may be obtained for apprentices of all kinds as long as they are employed in their parents' undertaking, and for persons temporarily employed in workers' colonies or similar charitable institutions during unemployment (section 174).

At their own request exemption may be granted to persons in receipt of an invalidity pension, or suffering from disablement to the extent of at least two-

thirds, provided that the poor relief authority which is provisionally liable for their maintenance consents. Similarly, at his own request, any person who has received benefit from his fund for the maximum permissible period may be exempted from insurance for the duration of his incapacity for work or the necessity for curative treatment (section 173)

VOLUNTARY INSURANCE

Continued Insurance for Persons Previously Insured Compulsorily

On giving up insurable employment, every person may, as long as he resides in the country, continue to be insured with his fund as a voluntary member. This right is conditional upon a minimum period of 26 weeks of compulsory insurance during the last 12 months or of at least six weeks immediately before giving up insurable employment (section 313).

Voluntary Insurance for Persons Outside the Scope of Compulsory Insurance

The following persons may enter into insurance voluntarily, provided that their total annual income does not exceed 3,600 marks:

(1) Persons belonging to classes of workers liable to insurance, but who, for any reason, are exempted;

(2) Members of the family of the employer who work in his undertaking without a specific agreement for employment, and without remuneration.

(3) Persons engaged in industry, and other owners of undertakings who as a rule employ no persons liable to insurance in their undertakings, or at most two such persons

The sickness fund may insist upon a medical examination, and may refuse admission to persons suffering from disease. It may, moreover, prescribe an age limit.

A person may remain affiliated as a voluntary member as long as the conditions under which he was admitted are unaltered. The fact that his income rises above the limit of 3,600 marks a year is not a reason for bringing his membership to an end. Voluntary insurance ceases when the insured person leaves the country, resigns, becomes insured with another fund, or fails to pay the contributions due on two consecutive pay-days (section 314). Voluntary members incapable of work retain their membership as long as the fund is bound to grant them benefits (section 314).

Statistics

GENERAL AND OCCUPATIONAL STATISTICS OF THE POPULATION

Population

According to information supplied by the German Government, the population of Germany was 59,178,185 in 1920 and 62,348,782 in 1925.

Distribution of Population by Occupations

According to information supplied by the German Government, the employed population of Germany was 23,000,000 in 1920 and 26,035,000 in 1925, and the occupied population 29,000,000 in 1920 and 31,985,000 in 1925

Distribution of Population by Age and Sex

The following particulars relating to the distribution of the population of Germany by age groups and by sex in the years 1910 and 1923 are taken from *Statistik des deutschen Reichs* (Vol. 240, p. 202).

Age group	Male population per thousand		Female population per thousand	
	1 December 1910	Middle 1923	1 December 1910	Middle 1923
Under 1	26.3	21.1	24.9	18.7
1 to 5	98.0	77.8	94.4	69.6
5 to 10	115.8	76.2	111.9	69.5
10 to 15	108.2	109.8	104.7	100.9
15 to 20	98.1	110.1	95.3	101.7
20 to 25	87.4	98.6	85.1	96.7
25 to 30	78.2	75.7	76.4	87.7
30 to 35	75.0	67.3	73.4	78.0
35 to 40	65.3	65.1	63.9	70.1
40 to 45	56.5	62.6	56.3	63.6
45 to 50	47.8	61.2	48.7	59.8
50 to 55	40.8	50.7	34.5	48.9
55 to 60	32.2	48.8	35.6	41.7
60 to 65	26.0	32.6	30.6	34.2
65 to 70	19.9	22.7	24.0	25.4
70 to 75	13.3	15.0	16.5	17.9
75 to 80	7.1	7.6	9.2	9.8
80 to 85	1.3	3.2	4.0	4.3
85 to 90	0.9	0.8	1.3	1.2
Over 90	0.2	0.1	0.3	0.3

Birth and Death Rates

The birth rate before the war was rapidly falling, the upward movement of 1920 was only of brief duration. The birth rate reached in 1924 its minimum of 20½ births per 10,000 inhabitants, as compared with 27½ births in 1913. In spite of the improvement in the death rate, the surplus of births over deaths is less by one-third in 1924 than the surplus in the years immediately before the war.

The following table gives the birth and death rates and the surplus of births over deaths (not including still-births) per 10,000 in the years 1871 to 1925.

Year	Birth rate	Death rate	Surplus of births
1871-1880	39.1	27.2	11.9
1881-1890	36.8	25.1	11.7
1891-1910	39.2	18.6	14.3
1911	28.6	17.3	11.3
1912	28.3	15.6	12.7
1913	27.5	15.0	12.4
1914	26.8	19.0	7.8
1915	20.4	21.4	-1.0
1916	15.2	19.2	-4.0
1917	13.9	20.5	-6.6
1918	14.3	24.8	-10.5
1919	20.0	15.6	4.5
1920	25.9	15.1	10.8
1921	25.3	13.9	11.3
1922	22.9	14.4	8.5
1923	21.0	13.9	7.1
1924	20.4	12.2	8.2
1925	20.6	11.9	8.7

STATISTICS OF INSURED PERSONS

Number of Insured Persons

A general view of the development of sickness insurance is offered by the following table, which indicates in millions the total population and the insured population for each sex.

Year	Men		Women	
	Total population	Insured population	Total population	Insured population
1888	23	4	25	0.9
1893	25	6	25	2
1898	26	7	28	2
1904	29	8	30	3
1908	31	9	31	3
1913	33	9	33	4
1914	33	10	34	6
1918	28	7	31	7
1924	30	10	32	7
1925	30	11	32	7

A more detailed table taken from *Statistik des deutschen Reichs* (Vol. 324) and completed by information for 1924 taken from *Wirtschaft und Statistik*, No. 21 of 1925, indicates the total number of persons compulsorily and voluntarily insured in sickness funds operating under the Federal Insurance Code and in mining funds and substitute funds for the years 1914 to 1925:

Year	Total membership (in thousands)	Membership of funds operating under Insurance Code (in thousands)	Membership of mining funds (in thousands)	Membership of substitute funds (in thousands)
1914	16,526	15,608	916	173
1915	14,584	13,840	743	190
1916	14,278	13,500	776	290
1917	15,225	14,176	876	413
1918	15,573	14,432	951	465
1919	17,241	15,840	1,109	723
1920	18,780	17,088	1,277	816
1921	19,028	17,442	1,120	—
1922	20,185	18,362	1,099	—
1923	19,999	18,112	1,071	—
1924	19,121	17,288	876	957
1925	20,175	18,235	818	1122

The reduction from the figure of 1923 to that of 1924, amounting to about 4 per cent, may be explained by the unemployment crisis which began in 1924. After the stabilisation of the mark the number of insured women decreased, partly because of the extension of the system of family allowances. If one compares the numbers of insured persons in 1924 and in 1914, one finds that, in spite of the loss of about 10 per cent of the membership in consequence of the Peace Treaty, the total number of insured persons is 20 per cent. greater in 1924.

The income limit for liability to insurance has several times been raised during post-war years, and was fixed by an Order of 10 January 1925 at 2,700 marks a year.

The ratio of compulsorily to voluntarily insured persons was as follows:

1914	14 to 1
1919	9 to 1
1920	
1921	
1922	10 to 1
1923	9 to 1
1924	10 to 1
1925	10 to 1

It is to be observed that, by the terms of German legislation, compulsorily insured persons who remain affiliated to the fund to which they were affiliated at the time of their entry into insurance are regarded as voluntary members; such persons are voluntarily insured with reference to the fund in question, but compulsorily insured from the standpoint of the insurance scheme as a whole.

The following table shows, in the case of funds operating under the Insurance Code, the absolute numbers of compulsory and voluntary members and the proportion of voluntary members per hundred compulsory members during the years 1914 to 1925.

Year	Number of compulsory members (in thousands)	Number of voluntary members (in thousands)	Number of voluntary members per cent. of compulsory members
1914	14,575	1,034	7.1
1920	15,382	1,706	11.1
1921	15,772	1,670	10.6
1922	16,684	1,678	10.1
1923	16,377	1,735	10.6
1924	15,730	1,558	9.9
1925	16,568	1,657	10.0

Distribution of Insured Persons by Sex

The following table shows the proportion of the sexes on the one hand among compulsory members and on the other among voluntary members:

Year	Insured women per hundred men compulsorily insured	Insured women per hundred men voluntarily insured
1914	54.8	141
1920	57.4	173.1
1921	56.8	184.1
1922	56.4	189.1
1923	54.3	193.4
1924	54.1	185.2
1925	55.4	168.4

It will be seen that about one-third of compulsorily insured persons are women, while among the voluntary workers women form nearly two-thirds of the total number.

The proportion of women during the first years following the war (57.4 per hundred men compulsorily insured) diminishes gradually from year to year.

Distribution of Insured Persons by Occupation

The *Statistik des deutschen Reichs* does not state how the insured population is distributed among the different occupations. Nevertheless, according to the different types of funds, one may arrive at the following grouping of insured persons

Occupational group	Number of persons, in thousands	
	1924	1914
Industrial wage-earners	12,498	10,538
Voluntary members	1,436	1,034
Domestic servants	1,112	1,281
Agricultural wage-earners	1,876	2,234
Persons working at home on their own account	232	246
Unpaid apprentices	127	128
Temporary workers	120	139
Members of mining funds	857	916
Members of substitute funds (mainly commercial workers)	850	390

Number of Insured Persons' Dependants Entitled to Benefits in Kind

There are no precise statistics of the number of dependants entitled to the additional benefit of family insurance. Estimates have however been made by the Federal Statistical Office according to which this benefit was granted in 1914 to 4,700,000 and in 1924 to 14,300,000 dependants.

According to an estimate reproduced in a memorandum submitted by the German Federation of Doctors on the cost of medical benefit under sickness insurance, the total number of dependants upon whom title to benefits in kind might be conferred was in 1922 16.4 millions, viz

1,000,000 persons over the age of 70,
4,500,000 wives of insured persons,
1,500,000 over 14, and
9,400,000 children under 14.

Taking into account the increase in the number of insured persons in 1923, one may estimate that the number of dependants upon whom the title to benefit might be conferred in that year was 17.5 millions, or between 0.83 and 0.86 dependant per insured person. The number of dependants upon whom title to benefit has actually been conferred is calculated by multiplying 17.5 by the proportion of the membership of sick funds which have included family insurance among their additional benefits, that is to say 93 per cent, so that the total number of dependants entitled to medical benefit would be 16.5 millions. This figure, somewhat high in view of the official estimate must be accepted with all reserve.

The Year-Book for 1925 published by the General Union of Local Sickness Funds of Germany (p. 283) contains information on the remarkable development of family insurance at the hands of local sickness funds. According to the Year-Book, 95 per cent. of local funds, which include 39 per cent. of the total membership of local funds, have introduced family insurance. All the local funds of the large towns have provided this additional benefit for the whole of their membership. The same is the case in the medium sized towns, while in the small towns 92.62 per cent. of the funds with 96.32 per cent. of the membership, have introduced family insurance and finally of the country funds, 93.98 per cent. have provided family insurance for 97.48 per cent. of their members.

According to information supplied by 199 funds with a membership of 1 013 893, there were in 1925, for every 100 insured persons, 46.9 who had in

their households dependants upon whom the benefits of family insurance might be conferred, and the number of such dependants amounted to 72 per cent of the insured persons.

Relation of Insured to Occupied and Total Population

The growth in the proportion of insured to total population is shown by the following comparison. In 1888 the sickness funds comprehended 17 per cent. of the male and 3 per cent of the female population in their membership, or 10 per cent. of the entire population, while in 1924 the figures had risen respectively to 33, 21 and 27 per cent.

The next table indicates the number of insured persons per hundred inhabitants:

Year	Number of insured per hundred inhabitants
1914	23
1915	20
1916	20
1917	21
1918	22
1919	26
1920	32
1921	29
1922	30
1923	29
1924	28
1925	32

Further, on the basis of figures communicated by the Ministry of Labour, it has been possible to determine the relation between the total number of insured on the one hand and the occupied and employed population on the other for 1925.

Relation of insured to wage-earning population in 1925:

$$\frac{\text{Insured population } 20,000,000}{26,035,000} = 76.8 \text{ per cent.}$$

Relation of insured to occupied population in 1925:

$$\frac{\text{Insured population } 20,000,000}{31,985,000} = 62.5 \text{ per cent.}$$

GREAT BRITAIN, NORTHERN IRELAND, AND IRISH FREE STATE

COMPULSORY INSURANCE

According to the National Health Insurance Act, 1924, in Great Britain and Northern Ireland, and to the National Health Insurance Acts, 1911-1925, in the Irish Free State¹, all persons of the age of sixteen and upwards, of either sex, whether British (Irish) subjects or not, who are employed within the meaning of the Acts are, with certain exceptions, subject to compulsory insurance (section 1) and are known as employed contributors.

Six classes of employment are enumerated as being within the meaning of the Acts and so rendering the persons engaged in them insurable as employed contributors, subject to the exceptions mentioned below:

(i) Employment in Great Britain (Irish Free State) under a contract of service, or under a contract of apprenticeship with a money payment (British and Irish ref First Schedule, Part I, (a)).

The vast majority of insured persons come within the scope of the Acts because they are employed under a contract of service. There is no statutory

¹ Unless it is indicated otherwise, the legislation referred to in this analysis is the National Health Insurance Act, 1924, in the case of Great Britain and Northern Ireland, and the National Insurance Act, 1911, as amended, in the case of the Irish Free State.

definition of "contract of service", but it is understood to mean a mutual agreement or understanding that the worker shall render personal services, subject to a right on the part of the employer to exercise control and direction over him as to the method of performance of his duties, in return for some specific remuneration in money or in kind or other benefit or privilege. In the case of a contract of apprenticeship the employment is not insurable unless a definite and regular money payment is made in return for the services rendered.

(ii) Employment in Great Britain (Irish Free State) under a local or other public authority (unless excluded by special order) (British ref.: First Schedule, Part I, (d), Irish ref.: First Schedule, Part I (e))

(iii) Employment in the armed forces as seaman, marine, soldier or airman (British ref.: section 57; Irish ref.: Act of 1923, section 20).

The Acts indeed except employment in the naval, military and air forces *except as otherwise provided* (British and Irish ref.: First Schedule, Part II, (a)), but the effect of sections 57 and 20 is to include almost all persons (other than those of commissioned rank) engaged in such employment.

(iv) Employment as a member of the crew of a ship registered or owned in Great Britain (Irish Free State) (British and Irish ref.: First Schedule, Part I, (b)).

(v) Employment in Great Britain (Irish Free State) as an outworker, unless excluded by special Order (British and Irish ref.: First Schedule, Part I, (c)).

An outworker is a person who works at home or in his own workshop on articles or materials given out to him by a person for the purpose of the latter's business

(vi) Employment in Great Britain (Irish Free State) in plying for hire with any vehicle or vessel which is hired from the owner (British ref.: First Schedule, Part I (e); Irish ref.: First Schedule, Part I, (d))

Under this provision a certain class of cabmen, who would not otherwise be covered, are brought within the scope of the Act.

Special Classes of Employed Contributors

The great majority of employed contributors are members of approved societies. Two classes, however, are insured under different arrangements: members of the Navy, Army and Air Force Insurance Fund and Deposit Contributors. Moreover, three classes who may be members of approved societies, namely, insured women who give up work on marriage, foreign-going sailors in the mercantile marine and seamen, marines, soldiers and airmen (not members of the Navy, Army and Air Force Insurance Fund) are the object of special provisions

Exclusion and Exemption

Excepted Employments

Certain employments which would otherwise be employments within the meaning of the Acts are expressly excluded from compulsory insurance. The exclusion is based on various grounds, of which the principal are that the person employed is able to cover his own risk, or is already provided for by the terms of his employment or that the employment is of a subsidiary or casual nature.

The excepted employments are as follows:

(i) Employment in a non-manual capacity at a rate of remuneration exceeding two hundred and fifty pounds a year (British ref.: First Schedule, Part II, (k), Irish ref.: First Schedule, Part II, (g), and Act of 1919)

This is the most important exception.

(ii) Certain employments under a local or public authority, namely, chaplain, medical practitioner, coroner, public analyst, registrar of births, deaths and marriages (British ref.: First Schedule, Part I, (d), and Employment under Local and Public Authorities Order, 1924; Irish ref.: Act of 1913, section 6, and Employment under Local and Public Authorities (Exclusion) Order, 1914).

(iii) Employment under the Crown (State) or a local or public authority, or as a salaried official of a railway or other statutory company entitled to rights in a superannuation fund established by Act of Parliament, where the

Minister of Health¹ (Irish Insurance Commissioners) certifies that the terms of the employment are such as to secure provision in respect of sickness and disablement on the whole not less favourable than the corresponding health insurance benefits (British and Irish ref. First Schedule, Part II, (b), (c)).

Certificates are issued in respect of the employments specified, they cannot be obtained by ordinary companies or private employers. They are granted after examination of the provision made for sickness and disablement. It is not required that the benefits provided should be precisely on the same lines as those of the Act, but it is necessary that their actuarial value should be at least equally great.

In Great Britain and Northern Ireland gas companies and other statutory undertakers whose superannuation funds are not established by Act of Parliament are enabled by the Widows', Orphans' and Old-Age Contributory Pensions Act, 1925, to obtain exception, coupled with total or partial exception from pensions insurance, if the Minister of Health certifies that provision is made for securing benefits not less favourable than *all* the health insurance benefits (other than additional benefits) as well as the appropriate pensions benefits.

(iv) Employment as a teacher for whom provision is made by the Teachers (Superannuation) Acts, 1918 to 1925, or the corresponding Acts in force in Scotland and Ireland, and employment as a pupil teacher, student teacher or monitor (British ref. First Schedule, Part II, (d), (e), (f), (g), (h), Irish ref.: First Schedule, Part II (d)).

(v) Employment of a casual nature otherwise than for the purposes of the employer's trade or business (British ref. First Schedule, Part II, (l); Irish ref. First Schedule, Part II, (h)).

Typical examples of employment of this character are found in the occasional employment by a householder of a charwoman or gardener.

(vi) Employment of any class which may be specified in a special Order as being subsidiary and not a principal means of livelihood (First Schedule, Part II, (m)).

The classes of employment which have been specified as being subsidiary are certain part-time employments in connection with religious worship, under the Crown, under local authorities, in theatres, certain seasonal agricultural employments, and a number of miscellaneous employments usually of a part-time character (British ref. Subsidiary Employments Consolidated Order, 1924; Irish ref. Subsidiary Employments Consolidated Order (Ireland), 1914).

(vii) Employment on an agricultural holding without money payment, and employment without money payment either by a parent or by an employer who fully maintains the employee (British ref.: First Schedule, Part II, (j); Irish ref.: First Schedule, Part II, (f)).

(viii) Employment of a wife by her husband or vice versa (British ref.: First Schedule, Part II, (p); Irish ref.: First Schedule, Part II, (l)).

(ix) Employment as an agent paid by commission or share in profits who is mainly dependent upon his earnings from another occupation or as such an agent for several employers where the employment under no one of the employers is that on which he is mainly dependent (British ref.: First Schedule, Part II, (v), Irish ref.: First Schedule, Part II, (e)).

(x) Employment as an outworker to whom articles or materials are given out, but who is not himself substantially engaged in their actual manipulation (British ref. First Schedule, Part I, (c) and Outworkers' Order, 1924; Irish ref.: First Schedule, Part I, (c), and Outworkers' Exclusion Orders (Ireland), 1914 and 1924).

(xi) Employment in the mercantile marine of a seaman who is neither domiciled nor resident in the United Kingdom, the Irish Free State, or the Isle of Man (British ref.: section 62, (4), Irish ref.: section 48, (3)).

In the case of such employment however, the employer is required to pay his share of the contribution, except when the ship is engaged in regular trade on foreign stations.

Exempt Persons

An exempt person is one who is employed within the meaning of the Act,

¹ Minister of Health should be read as including the Scottish Board of Health and the Health Board for Northern Ireland, where Scotland and Northern Ireland are concerned.

but who is exempted from liability to be insured because he has proved to the satisfaction of the Minister of Health (Irish Insurance Commissioners) that he is either:

- (1) in receipt of a pension or private income of at least £26 a year, or
- (2) dependent for his livelihood upon some other person; or
- (3) dependent on a non-insurable occupation, or
- (4) employed intermittently and for less than a prescribed number of weeks per year (13 in each of two consecutive years) (British and Irish ref.: section 2).

Exempt persons differ from persons engaged in excepted employments in that they are not wholly excluded from the operation of the scheme. They remain insured persons until they have made a claim for exemption which has been accepted. The employer of an exempt person has to pay the employer's share of the contribution due in respect of an insured person (section 6), but the exempt person is not required to contribute. Exempt persons are entitled to medical benefit (section 12) but to no other benefits. In the Irish Free State they are entitled to sanatorium benefit and in Northern Ireland to sanatorium benefit and reduced sickness benefit. They are not included within the legal definition of insured persons for health insurance purposes. Their number is insignificant.

VOLUNTARY INSURANCE

The Acts of 1911 and 1913 conferred the right of voluntary insurance upon persons not engaged in insurable employment, but dependent on their work for their livelihood and with incomes of not more than £160 a year, and also upon certain persons who had been engaged in insurable employment, but had ceased to be so. In 1918, however, owing to the small number of persons who took advantage of the opportunity to become voluntary contributors the right was withdrawn from the first class and confined to the second class.

With some exceptions of negligible importance, the title to voluntary insurance is limited to persons who cease insurable employment after having been insurably employed for at least 104 weeks and give notice within a year of ceasing to be employed.

No married woman may become a voluntary contributor.

Voluntary contributors pay the whole contribution themselves. Apart, however, from this difference, and the fact that a greater regularity in the payment of contributions is required of them and more onerous conditions are imposed with regard to the discharge of arrears, their situation is identical with that of employed contributors. Voluntary contributors, however, whose total income from all sources exceeds £250 a year are not entitled to medical benefit and are allowed to pay a smaller weekly contribution.

In Great Britain and Northern Ireland, the Widows', Orphans' and Old-Age Contributory Pensions Act, 1925, re-opened for a limited period the option for those who failed to give notice within the year, and that Act also confers a right of voluntary insurance upon persons who have been engaged for two years in any employment excepted on the ground of equivalent treatment, and upon male exempt persons who have been insurably employed for two years.

Statistics

Great Britain

GENERAL AND OCCUPATIONAL STATISTICS OF THE POPULATION

Population

The estimated population on 30 June in each of the years 1914, 1921, 1922, 1923 and 1924 was as follows

Year	Population in thousands
1914	41,708
1921	42,769
1922	43,062
1923	43,399
1924	43,629
1925	43,783
1926	43,970

Number of Gainfully Occupied Persons

According to the Census of 1921 the number of gainfully occupied persons aged twelve years or over was 19,357,319.

Number of Employed Persons

According to the Census of 1921 the number of employed persons aged twelve years or over was 17,403,000. Of these 971,000 were aged under 16 years. Hence the total number of wage-earners of insurable age was 16,432,000.

Number of Persons Working on their own Account (not Employers)

According to the Census of 1921 the number of persons working on their own account was 1,207,000

Distribution by Occupation of Gainfully Occupied Persons

According to the Census of 1921 the distribution by occupation of the gainfully occupied population distinguished as (i) employers and persons working on their own account and (ii) employed persons was as follows:

Occupation	Employers and independent	Employed	Total
Commerce and finance	585,173	1,173,574	1,758,747
Agriculture and fishery	375,522	1,124,667	1,500,189
Transport	63,278	1,601,854	1,665,132
Liberal professions and public administration	122,127	1,192,391	1,314,518
Personal service	243,363	1,972,873	2,216,256
Industry and mining	553,138	10,349,339	10,902,477

STATISTICS OF INSURED PERSONS

Number of Insured Persons

The total number of persons insured either compulsorily or voluntarily each year since the commencement of the Act is shown in the following table:

Year	Total insured population in thousands
1913	13,223
1914	13,619
1915	14,060
1916	14,814
1917	15,333
1918	15,852
1919	15,413
1920	15,234
1921	15,069
1922	15,082
1923	15,134
1924	15,411
1925	15,615
1926	15,992

(Annual Reports of the MINISTRY OF HEALTH and of the SCOTTISH BOARD OF HEALTH, and ROYAL COMMISSION ON NATIONAL HEALTH INSURANCE: Evidence, Appendix, Part I)

The number of voluntarily insured persons rose from 19,000 in 1913 to 37,000 in 1924. From 1926 onwards, it is expected that the number will be

increased by at least 100,000 as the result of the inducement offered by the Widows', Orphans' and Old-Age Contributory Pensions Act, it is impossible to become a voluntary contributor under this Act without at the same time becoming such also under the Health Insurance Act

Distribution of Insured Persons by Sex

The following figures indicate that two-thirds of the insured population consist of men:

Year	Men (in thousands)	Per cent.	Women (in thousands)	Per cent.
1913	9,287	70	3,936	30
1914	9,622	71	3,997	29
1915	9,925	70	4,135	30
1916	10,293	70	4,521	30
1917	10,492	69	4,841	31
1918	10,682	67	5,169	33
1919	10,284	67	5,129	33
1920	10,180	67	5,054	33
1921	10,183	67	4,886	33
1922	10,192	68	4,890	32
1923	10,232	68	4,902	32
1924	10,392	67	5,019	33
1925	10,511	67	5,103	33
1926	10,794	67	5,198	33

(Annual Reports of the MINISTRY OF HEALTH and of the SCOTTISH BOARD OF HEALTH.)

Distribution of Insured Persons according to Type of Institution with which they are Insured

The vast majority of insured persons are members of approved societies, but several hundred thousand belong to the Navy and Army Fund and the Deposit Contributors' Fund, and are subject to a different regime.

Year	Approved societies		Navy, Army and Air Force Fund		Deposit Contributors' Fund	
	Absolute figures (in thousands)	Percent-ages	Absolute figures (in thousands)	Percent-ages	Absolute figures (in thousands)	Percent-ages
1913	12,770	96.6	106	0.8	347	2.6
1914	13,051	96.0	245	1.8	323	2.4
1915	13,307	94.6	430	3.1	324	2.3
1916	13,878	93.7	590	4.0	347	2.3
1917	14,166	92.4	780	5.1	386	2.5
1918	14,598	92.0	860	5.5	394	2.5
1919	14,591	94.7	360	2.3	462	3.0
1920	14,585	95.7	260	1.7	389	2.6
1921	14,529	96.4	255	1.7	285	1.9
1922	14,572	96.6	232	1.5	278	1.9
1923	14,682	97.0	175	1.2	269	1.8
1924	14,975	97.0	167	1.1	269	1.8
1925	15,178	97.2	165	1.1	272	1.7
1926	15,554	97.2	156	1.0	282	1.8

Relation of Insured to Occupied and Total Population

The insured population in 1921 represented, according to the Census of that year:

35	per cent of the total population
78	" " " " occupied population
86	" " " " employed population
92	" " " " " " of insurable age.

STATISTICS OF UNINSURED PERSONS

Persons in Excepted Employments

The number of persons excepted on the ground of equivalence of treatment — civil servants, police, railway clerks, and teachers — was estimated in 1924 at 422,000 (Royal Commission on National Health Insurance: *Evidence*, Appendix, Part I).

Exempt Persons

The number of exempt persons in England in 1924 was 33,600, of whom 24,700 obtained exemption on the ground of the possession of income of £26 a year

Northern Ireland

GENERAL AND OCCUPATION STATISTICS OF THE POPULATION

The population of Northern Ireland, in the middle of 1926, was 1,255,881, of whom 608,396 were males and 647,485 were females. In 1911 the total population was 1,250,531.

The number of gainfully occupied persons aged 20 years and upwards, according to the Census of 1911, was 452,040, or 60.2 of the 1911 population of that age (*Ulster Year Book*, 1926, p. 7).

STATISTICS OF INSURED PERSONS

Number of Insured Persons

The estimated number of insured persons was

in 1923	325,000
in 1924	323,200
in 1925	331,053

(Annual Report of the MINISTRY OF LABOUR for the years 1923-1924, p. 84; 1925 figure communicated by Ministry of Labour.)

Distribution of Insured Persons by Sex

The numbers of men and women insured are respectively as follows:

Year	Men	Per cent	Women	Per cent.
1923	193,000	59	132,000	41
1924	195,000	60	128,200	40
1925	195,505	59	135,548	41

Distribution of Insured Persons according to the Type of Institution with which they are Insured

As appears from the following table, all but an insignificant number of insured persons are members of approved societies:

Year	Approved societies		Navy, Army and Air Force Fund		Deposit Contributors' Fund	
	Absolute figures	Per cent	Absolute figures	Per cent	Absolute figures	Per cent.
1923	320,500	98.6	1,000	0.3	3,500	1.1
1924	319,000	98.8	500	0.15	3,700	1.1
1925	327,535	99.0	468	0.14	2,950	0.9

Relation of Insured to Occupied and Total Population

The number of insured persons in 1924 represents 46 per cent. of the population between the ages of 15 and 70, as enumerated at the 1911 Census, insured men represented similarly 52 per cent. and insured women 34 per cent.

The number of insured persons between the ages of 16 and 20 years at the end of 1925 was 46,398, while the total number of insured was 331,053. Hence the number aged 20 years and upwards at the same date was 287,655. Comparing this figure with that of the gainfully occupied population of the same age groups in 1911 (452,040), we find that the ratio of the former to the latter is 68 per cent.

STATISTICS OF UNINSURED PERSONS

The number of persons excepted from compulsion to insure on account of equivalent treatment in 1925 was 4,672, and the number of exempt persons was 733 (figures communicated by the Ministry of Labour).

Irish Free State

GENERAL STATISTICS OF THE POPULATION

The population of the Irish Free State in the middle of 1926 was estimated at:

1,505,916 men
1,465,886 women
<hr/> 2,972,802

STATISTICS OF INSURED PERSONS

The number of insured persons in 1926 is estimated at 450,000 compulsorily insured and exempt persons, and 100 voluntarily insured, of whom 437,650 are members of approved societies and 9,750 are deposit contributors, 1,660 members of the Military Forces Fund, and 1,040 exempt persons.

The number of insured persons represented about 15.1 per cent. of the population

GREECE

COMPULSORY INSURANCE

Compulsory insurance as instituted by Act No. 2868 of 1923 covers wage-earners in general, that is to say, all persons working otherwise than on their own account in industrial, handicraft, and commercial undertakings or establishments, including undertakings in the building and transport industries.

The expression "persons engaged otherwise than on their own account" means wage-earning and salaried employees and servants of both sexes employed for remuneration, irrespective of the way in which the said remuneration is calculated (section 1).

Exclusion

Persons engaged in home industries are not liable to compulsory insurance, but may voluntarily apply for inclusion. Such persons are those working in industries or handicrafts, either alone or jointly with members of the same family, in their home or in their own workplace, at the orders of another person carrying on trade, or on his account.

Further, persons not customarily, but only temporarily and by way of exception, engaged in the work mentioned in section 1, and also persons engaged for casual work, are not liable to compulsory insurance (section 2)

VOLUNTARY INSURANCE

The law contains only one mention of voluntary insurance. It provides that home workers who are not subject to compulsory insurance may be allowed to insure voluntarily.

HUNGARY

COMPULSORY INSURANCE

A system of compulsory insurance was established in Hungary by Act No XIX of 1907. Insurance was made compulsory in the case of all persons without regard to sex, age or nationality, who are employed, whether permanently, provisionally, as supernumeraries, or temporarily, within the territory of the Holy Crown of Hungary in certain enumerated industries and occupations, which are as follows:

- (1) Any occupation coming under the Industrial Act (No XVII of 1884), including the State monopolies and undertakings in connection therewith.
- (2) Any employment for wages not coming under the Industrial Act but, notwithstanding, carried on as a trade or for purposes of gain (technical offices, agencies, theatres, chemists' shops, hospitals, etc.)
- (3) Mines and smelting works, salt works or other works for the preparation of mining products, quarries, sand-pits, gravel-pits, and clay-pits.
- (4) Construction of roads, bridges, tunnels, etc., water, gas, and electric works.
- (5) Industries in which inflammable, poisonous, or explosive materials are prepared.
- (6) Laboratories
- (7) Slaughter-houses and ice-works
- (8) Railways and post, telegraph and telephone undertakings.
- (9) Shipping, loading, and shipbuilding.
- (10) Dredging and harbour works and timber floating.
- (11) Carrying businesses, warehouses, and commercial stores
- (12) Industries allied to agriculture
- (13) Public institutions.
- (14) Undertakings or offices conducted by the State or local authorities.
- (15) Workrooms attached to public educational institutions.
- (16) Clubs, industrial corporations, and sickness funds (section 1)

The scope of compulsory insurance was extended to cover domestic servants by Order No. 5,400 of 1919.

Apprentices who receive either low wages or a wage of less than the usual amount are subject to compulsory insurance.

Home Workers

Insurance is also compulsory in the case of persons who work in their own workplaces or dwellings for purposes of gain by order or on account of other manufacturers, even if they themselves provide the material and other means of production and if they work at the same time on their own account (section 2)

Employment Abroad and Treatment of Foreigners

Insurance is compulsory in the case of Hungarian subjects employed permanently abroad but in the service of a firm in Hungary, provided that they are not already insured under the laws of the State in the territory of which they exercise their trade. Hungarian subjects employed temporarily abroad in the service of a firm in Hungary enjoy equally the benefits of insurance whether in Hungary or abroad (section 4). Foreigners employed by firms in Hungary are entitled to the same treatment as Hungarian subjects (section 5). Undertakings which extend their activity outside the country are required to insure in one country only; for this purpose the domicile of the undertaking is the determining factor. Notwithstanding, if the undertaking is represented by a permanent department in Hungary, insurance under the Hungarian Act shall be compulsory in the case of persons employed within the sphere of action of such department (section 6).

Special Schemes

Certain classes of workers, although subject to the Act of 1907, belong to special institutions and are insured under special conditions: they are railwaymen, miners, postal workers, river boatmen and tobacco workers.

Exclusion

The Hungarian scheme does not make insurance compulsory for agricultural workers.

Non-manual workers earning more than 24,000,000 crowns per year are excluded.

State civil servants are also excluded from the general scheme of compulsory insurance, but they are entitled to their salaries in case of sickness and belong to a special insurance scheme whereby they and their families are provided with medical benefit in case of sickness (Act No. XLVI of 1921 and Order No. 40000 of 1923).

VOLUNTARY INSURANCE

Continued Insurance for Persons Previously Insured Compulsorily

Certain groups of persons formerly liable to compulsory insurance may, under certain conditions, be entitled to remain insured as volunteers without passing a medical examination and without regard to their age. These groups are as follows:

- (1) Persons who cease to exercise an occupation subject to insurance, but who, nevertheless, remain essentially wage-earners
- (2) Persons formerly insured who are unemployed
- (3) Persons who cease to be insured because their salary is higher than the maximum limit.

Such persons may continue in insurance on two conditions:

- (1) That they have been insured either for six months during the year preceding the cessation of compulsory insurance or during 12 months in the course of the last two years
- (2) That they give notice of their intention to continue in the insurance as foreigners within four weeks after the cessation of compulsory insurance (Order No. 4790 of 1917).

Insured persons who are manual workers and who fulfil the above conditions may continue in insurance irrespective of their wages. On the other hand, in the case of non-manual workers who wish to remain insured, an income limit has been prescribed by Order No. 4650 of 1923: at the present time this limit is fixed at 8,400,000 crowns a year or 28,000 crowns a day.

Voluntary Insurance for Persons Outside the Scope of Compulsory Insurance

The opportunity of insuring voluntarily is also open to persons who have not previously been insured under the compulsory provisions of the Act. This opportunity is only open to certain classes, of which the following are

the most important persons working on their own account without assistance, members of the family of insured persons, and farm labourers and servants

Admission to voluntary insurance may, by the rules of sickness funds, be made conditional upon a medical certificate of good health, and, further, an age limit may be prescribed.

Statistics

GENERAL AND OCCUPATIONAL STATISTICS OF THE POPULATION

According to the Census of 1920, the population of Hungary was 7,980,143. At the end of 1924 it was estimated at 8,274,940.

The gainfully occupied population was shown by the Census of 1920 to number 3,752,714, and the wage-earning population to number 2,110,000. At the end of 1924 the occupied population had risen to 3,891,564 and the wage-earning population to 2,188,000

The data concerning the occupations of the population are shown in the following table, which, however, does not distinguish between wage-earners and independent workers.

Occupation	Occupied	Dependants	Occupied and dependants as per cent of total population
Agriculture	2,126,688	2,322,416	55.8
Mines, blastfurnaces	40,098	77,246	1.5
Manufacture	679,657	842,652	19.1
Commerce, banking	183,736	223,284	5.1
Communications	117,607	238,519	4.1
Public services, liberal professions	167,731	204,435	4.7
National defence	88,139	36,461	1.6
Unskilled workers	50,118	47,351	1.2
Retired and capitalists	98,954	97,871	2.4
Domestic servants	155,892	19,569	2.2
Unknown	44,094	117,625	2.0

STATISTICS OF INSURED PERSONS

In order to arrive at the total number of persons account must be taken not only of persons insured under the general scheme but of those covered by special schemes. The pre-war figures are valueless owing to the fact that under the Treaty of Trianon Hungary lost two-thirds of its agricultural population, and one-half of its industrial and commercial population.

Number of Persons Insured under General Scheme

The post-war figures of the number of persons insured compulsorily and voluntarily under the general scheme are as follows:

Year	Number of insured	Index No.
1919	560,510	100.0
1920	509,341	90.8
1921	599,431	106.9
1922	684,073	122.0
1923	709,042	126.5
1924	748,689	133.5

The increase since 1919 must be mainly attributed to the bringing in of domestic servants, who numbered 155,892 in 1920. The rise from 1923 to 1924 is most remarkable, seeing that from the beginning of 1924 the railway and postal workers (who numbered 46,713 in 1920) are no longer included in the statistics of the general scheme.

Number of Persons Insured under Special Schemes

Figures are available for 1924 in respect of special schemes for tobacco workers, miners and transport workers, but not for railway or postal workers. They refer to persons compulsorily or voluntarily insured:

Special scheme	Number of insured
Tobacco workers	6,356
Miners	63,685
Transport workers	15,085
	<hr/> 85,126

Total Number of Insured Persons

The statistics communicated by the Hungarian Government show a total of 963,794 insured persons at the end of 1924, so that there must be about 130,000 railway and postal workers insured. The total does not include civil servants who are required to belong to a fund providing medical aid only; they numbered 184,289 in 1924.

Distribution of Insured Persons by Sex

The distribution by sex of persons compulsorily or voluntarily insured under the general scheme is shown in the following table:

Year	Compulsory			Voluntary		
	Men		Women (absolute)	Men		Women (absolute)
	Absolute	Per cent.		Absolute	Per cent.	
1919	386,380	69.3	170,689	2,481	72.1	960
1920	336,638	66.7	168,045	3,911	80.0	747
1921	413,793	69.2	183,716	1,469	76.5	453
1922	466,055	68.4	215,006	2,501	83.0	511
1923	474,564	67.2	232,243	1,656	74.0	579
1924	493,529	66.0	253,839	817	61.9	504

Relation of Insured to Occupied and Total Population

The ratio of the insured to the total population in 1924 was:

$$\frac{963,794}{8,274,940}, \text{ or } 11.65 \text{ per cent.}$$

The ratio of the insured to the occupied population was:

$$\frac{963,794}{3,891,564}, \text{ or } 24.77 \text{ per cent.}$$

The ratio of the insured to the wage-earning population was:

$$\frac{963,794}{2,188,000}, \text{ or } 44 \text{ per cent.}$$

ITALY (New Provinces)

The Legislative Decree No. 2146 of 29 November 1925 has confirmed in the former Austrian and Hungarian territories now belonging to Italy the scope of the laws previously in force:

The obligation to insure against sickness is maintained in the case of all workmen and salaried employees (except the regular staff employed by the State), when such workmen or salaried employees are comprised at the time of the promulgation of the present Decree in the insurance set up by the Austrian Act of 30 March 1888 or in the Hungarian Act No. XIV of 1891 or by other legislation concerning this matter. The obligation applies likewise to workmen and salaried employees in undertakings which at the above-mentioned date were included in the scope of compulsory insurance . . . The scope of compulsory insurance also includes workmen and salaried employees who, although not actually covered by insurance, have contributed to a sickness fund during the year 1925 (section 5 of the Decree).

Thus in virtue of the above-mentioned Legislative Decree the scope of compulsory insurance in the new provinces is defined by two laws, viz.:

- (1) the Austrian Act No. 33 of 30 March 1888 applying to all the new territories except Fiume, and
- (2) the Hungarian Act No. XIV of 1891 applying to Fiume

The Decree of 4 March 1926 draws up common regulations applicable to the entire area of the new provinces.

- (1) for the interpretation of the Decree Law of 29 November 1925 defining the persons who remain insured under the laws which are maintained in force; and
- (2) for prescribing certain exemptions from compulsory insurance.

There will be examined below the scope of insurance as defined by the Austrian and Hungarian laws and the modifications or interpretations resulting from Italian legislation.

Provinces in which the Former Austrian Act of 30 March 1888 is in Force (All New Provinces except Fiume)

COMPULSORY INSURANCE

General Formula

All workmen and salaried employees covered by the Industrial Accidents Act are subject to sickness insurance, and as such are compulsorily insured. Compulsion therefore applies to works officials or wage-earners of both sexes, whether remunerated or not, in the service of undertakings covered by the Industrial Accidents Act: railways, inland navigation, manufacturing undertakings employing ordinarily more than 20 workers, and factories¹.

In accordance with the Industrial Accidents Act (section 3, subsection 2) the Minister is authorised to extend the scope of compulsory insurance to include undertakings where there is a risk of accident and especially of fire. The undertaking so brought under the Industrial Accidents Act is likewise brought within the scope of compulsory sickness insurance.

¹ The term "factory" means, irrespective of the number of workers employed in it, any undertaking producing or utilising explosives or permanently using motors operated by natural or animal force, as well as any forge or undertaking for dredging or well-boring.

Exclusion and Exemption

The following classes of workers are not covered by the Industrial Accidents Act, and are therefore outside the scope of sickness insurance

- domestic servants,
- wage-earners and salaried employees of undertakings employing less than 20 persons which, by reason of the manner in which they are carried on, cannot be considered as factories within the meaning of the Industrial Accidents Act,
- wage-earners and salaried employees of industrial undertakings using only temporarily a machine which does not belong to their equipment,
- persons working in the construction of one-story dwelling houses, factories or agricultural buildings, provided that such persons belong to the builder's family, live in the same commune, and are not engaged in building by way of trade

Exemption is provided for in the case of civil servants in receipt of fixed salaries, whether employed by the State, Departments, communes or public institutions (Sickness Insurance Act of 30 March 1888, section 2).

Exclusion is prescribed in the case of seamen and fishermen (Act of 30 March 1888, section 1) and workers engaged in agriculture and forestry (Act of 30 March 1888, section 3, subsection 1).

The Act of 30 March 1888 moreover provides that, until special regulations for their insurance have been issued, agricultural and forest workers shall be entitled in case of sickness to medical attention and maintenance at the cost of the employer for a period of four weeks

These provisions, however, only affect wage-earners and salaried employees of agricultural and forest undertakings covered by the Industrial Accidents Act (Act of 30 March 1888, section 3, subsection 2).

Lastly it must be observed that the Minister is, in virtue of the Industrial Accidents Act (section 3, subsection 1), authorised to exempt from accident insurance certain undertakings falling within the scope of the Act but which offer no risk to the persons engaged in them. Exemption entails for the worker employed in such undertakings a corresponding exemption from sickness insurance.

The political authorities of first instance are entitled to exempt from compulsory insurance, with the consent of the parties concerned, persons who in case of sickness are entitled for at least 20 weeks to their wages and medical treatment in the family of their employer.

VOLUNTARY INSURANCE

Voluntary insurance is open:

- (1) to employers in agriculture and forestry who desire to insure their staff and so to relieve themselves from the obligation of providing for a period of four weeks for the maintenance and medical attention of their workers who are covered by the Industrial Accidents Act; and
- (2) to persons working on their own account with the aid of members of their own family, but without paid helpers (home workers). The right to insure voluntarily applies not only to such workers but also to the members of their family who assist them (Act of 30 March 1888, section 3).

Province in which the Former Hungarian Act No. XIV of 9 April 1891 is in Force (Fiume)

COMPULSORY INSURANCE

Membership of a sickness fund is compulsory for all persons irrespective of sex, age or nationality, employed for more than eight days by the same employer for a wage not exceeding four florins a day:

- (a) in one of the occupations covered by the Industrial Act (Act No XVII of 1884);
- (b) in mines, factories, or other undertakings which work up mineral products, stone quarries, and sand and coal pits,
- (c) in large-scale building,
- (d) in the working of railways and in their workshops, and in the postal service;
- (e) in navigation and shipbuilding,
- (f) in the transport of goods, agencies, shops and warehouses.

Apprentices, voluntary workers and other persons who have not finished their training and are not remunerated at all or receive less than the normal wage are deemed to be employed in an industrial undertaking and as such to be subject to compulsory insurance (sections 2 and 3 of the Act).

Exclusion and Exemption

Temporary workers, i.e. those who hire their services to an undertaking for less than eight days, are excluded from the scope of compulsory insurance. So likewise are seamen and sea fishermen (final subsection of section 2 of the Act).

Exemption from insurance applies to all persons permanently employed for a fixed salary in undertakings belonging to the State or municipalities, or in public institutions, including the postal service and State factories and railways, provided that regulations guarantee to such persons in case of sickness the payment of their salary for at least 20 weeks, counting from the commencement of the sickness.

Exemption may be allowed in the case of persons employed in an undertaking belonging to the category of those the staff of which is liable to insurance, provided that such persons are entitled, in virtue of their contract of service, to receive from their employer free medical treatment or full wages, and that the factory inspectorate considers that the arrangements made for the provision of medical treatment or the payment of the wage are sufficiently secure.

VOLUNTARY INSURANCE

The following classes of persons are entitled to become voluntary members of sickness funds, unless the rules of the funds provide to the contrary:

- (a) persons who enter for a period of less than eight days the service of an undertaking whose staff, not including temporary workers, is liable to insurance;
- (b) persons receiving an annual salary of more than 1,200 florins, or a daily wage of more than 4 florins;
- (c) persons engaged in domestic industry,
- (d) artisans and independent workers,
- (e) foremen and manual workers in agricultural undertakings not subject to the Industrial Act, where the employer, with the consent of the persons concerned, applies for their admission;
- (f) the members of the family of persons insured compulsorily or voluntarily (Act No XIV of 1891, section 4)

Provisions Common to All the New Provinces

DEFINITION OF WORKERS SUBJECT TO INSURANCE

The scope of sickness insurance includes all wage-earners and salaried employees for whom, at the time when the Legislative Decree No. 2146 of 29 November 1925 came into force, membership of a sickness fund was compulsory in virtue of the Austrian and Hungarian legislation, as well as for

wage-earners and salaried employees belonging to such fund during the year 1925.

Insurance is also compulsory for all wage-earners and salaried employees, not mentioned in the previous paragraph, who are employed in undertakings falling within the category of those whose staff was, in accordance with the Austrian and Hungarian legislation, liable to insurance.

A person insured in virtue of the above provisions retains his rights even after he enters the employment of an undertaking whose staff is not liable to insurance, provided that the undertaking is situated within the new provinces.

Sickness insurance is also compulsory for members of the employer's family, when the latter are employed by him but are not legally dependent upon him.

Insurance is maintained on behalf of auxiliary workers provisionally employed and day-workers employed by the State who were insured previous to the promulgation of the Legislative Decree of 29 November 1925.

Those who are entitled to be insured in virtue of the Legislative Decree of 29 November 1925, or of the above provisions, retain their rights during the suspension of their employment, whatever may be the cause or the duration of such suspension.

The obligations of the employer do not cease by reason of the transformation, sale or transfer of the undertaking or by the total or partial cessation of operations, but only by the actual cessation of the entire industrial or commercial activity of his undertaking.

EXCLUSION AND EXEMPTION

Wage-earners permanently employed by the State, auxiliary workers permanently employed, and temporary workers are excluded from the scope of insurance even if they were insured before the promulgation of the Legislative Decree of 29 November 1925.

The prefect of a province may exempt from insurance persons working under a contract which guarantees to them in case of sickness either treatment at least equivalent to that prescribed in the Legislative Decree of 29 November 1925, or payment of full wages for at least six months from the commencement of the sickness.

The prefect grants exemption on the application of the employer or worker concerned. Appeal can be made from his decision to the Minister of National Economy.

JAPAN

COMPULSORY INSURANCE

All persons employed in a factory to which the Factory Act ¹ applies, or in a mine to which the Mining Act ² applies are, with certain exceptions, subject to compulsory insurance (Health Insurance Act No. 70 of 22 April 1922 ³, section 13).

Factories

The factories to which the Factory Act applies are:

- (1) factories where ten or more persons are regularly employed;
- (2) factories where work is of a dangerous nature or injurious to health (Factory Act, section 1).

The industries regarded as dangerous or unhealthy have been enumerated in a list too long for reproduction, but including, e.g. the manufacture of cotton, glass, dyes, rubber goods, paints, enamelled ironware, chemicals and explosives, the refining of metals and fats, tanning, ore crushing, and the stuffing and preparation of animals.

¹ Factory Act No. 46 of 28 March 1911, as amended by Act No. 33 of 29 March 1923.

² Mining Act of 1905, as amended by Act No. 22 of 22 July 1924.

³ Hereinafter referred to as H.I.A.

Mining

Practically all mines are covered by the Mining Act.

*Exclusion**Persons Excepted*

Certain persons employed in undertakings to which the Factory and Mining Acts apply are excluded from the scope of compulsory insurance, namely:

- persons temporarily employed,
- administrative employees whose annual remuneration exceeds 1,200 yen a year (H.I.A., section 13)

Undertakings and Industries Excepted

Several large classes of employed persons are outside the scope of health insurance because they are engaged in industries to which the Factory and Mining Acts do not apply: agriculture, commerce, transport by land and sea, public administration, factories not designated as dangerous and occupying less than ten workers, and excepted undertakings not using mechanical power.

The last group is excepted in virtue of section 1 of the Factory Act, which provides that factories to which it seems unnecessary for the Factory Act to apply may be excepted by Imperial Ordinance. In accordance with this provision, an Ordinance has been issued whereby a list of industries are excluded from the scope of the Factory Act, and consequently from that of the Health Insurance Act. These industries are mainly those in which paper, straw and bamboo are made up. Undertakings of this kind, however, are only excluded provided that they do not make use of mechanical power (Ordinance for the enforcement of the Factory Act as amended, para. 1, and Regulations in pursuance of the Factory Act as amended, para. 1)

Officials employed in State undertakings may provisionally be excepted from health insurance by the Minister for Home Affairs (Ordinance for the enforcement of the Health Insurance Act, final paragraph)

ELECTIVE INSURANCE

In the case of certain groups of undertakings the workers may elect in a body to subject themselves to the compulsory provisions of the Health Insurance Act. These are undertakings which, not falling within the scope of compulsory insurance are engaged in mining, manufacture, power generation, building, conveyance by tramways, and other modes of transporting goods and passengers, the loading and unloading of goods, and any other undertakings which may be designated by Imperial Ordinance (H.I.A., section 14).

An employer in any of these undertakings may, after having obtained the sanction of the competent Minister, cause all those persons employed in his undertaking to be insured who would have been insured if the undertaking had been covered by the Factory or Mining Acts. Before the sanction is given, the consent of a majority of the persons to be insured must be obtained in favour of the proposal (H.I.A., sections 14 and 15).

An employer who has caused his workpeople to be insured may also cause them to cease to be insured, provided that he obtains the sanction of the Minister for Home Affairs

VOLUNTARY INSURANCE

Voluntary insurance is instituted only on behalf of persons who have formerly been insured under the compulsory provisions of the Health Insurance Act. A person who ceases to be subject to compulsory insurance, but who has been insured for at least 180 days within the twelve months preceding the date on which he ceased to be insured, or who has been insured for at least 60 consecutive days up to the date just mentioned, is entitled to continue in insurance if he applies to be allowed to do so within ten days after ceasing to be insurable

(H.I A, section 20, and Ordinance for the enforcement of the Health Insurance Act, para. 10).

Statistics

GENERAL AND OCCUPATIONAL STATISTICS OF THE POPULATION¹

The total population of Japan in 1923 was 58,482,000, of whom 29,297,000 were men and 29,185,000 were women.

According to the estimate of the Government Statistical Bureau, the distribution of the population according to occupation was as follows in 1920

Occupation	Total population		Occupied population		Per cent of total population
	Number in 1,000's	Per cent	Number in 1,000's	Per cent	
Agriculture . . .	26,943	48.3	9,020	56.5	6.1
Fishing	1,492	2.7	390	2.4	0.7
Mining	1,021	1.8	446	2.8	0.8
Industry	10,865	19.5	3,630	22.7	6.5
Commerce	7,646	13.6	1,109	7.0	2.0
Transport	2,516	4.5	647	4.0	1.2
Public works . . .	2,992	5.3	263	1.7	0.5
Miscellaneous . . .	2,374	4.3	465	2.9	0.8
Total	55,849	100.0	15,970	100.0	28.6

The occupied population are not distinguished as wage-earners or persons working on their own account or as employers.

STATISTICS OF INSURED PERSONS

Since the Health Insurance Act does not come into force until 1927, no statistics of its operation are available. It has, however, been officially estimated that the number of persons to be insured under the Act will be 1,897,771.

Hence the insured population expressed as a percentage of the above figures for the total and of the occupied population is respectively 3.25 and 11.9.

LATVIA

COMPULSORY INSURANCE

General Formula

The Sickness Insurance Code of 1922 applies to all private, communal, and State undertakings, institutions, and other workplaces, and also to all private individuals employing labour for remuneration (section 1).

It renders liable to insurance all persons, without distinction of sex or age, who work or serve either in the undertakings mentioned in section 1 or under agreement or under the law or special regulations (section 2). Home workers are covered by this formula.

Special Classes of Workers

The Ministry of Labour is entitled to issue Orders concerning the application of the Code:

- (1) to persons working in co-operative groups (artels);

- (2) to persons employed in temporary and casual work, and
- (3) to owners of small-scale undertakings who have not more than three employees and work with them.

In virtue of this power, an Order was issued on 8 September 1923 (amended 25 April and 29 September 1924) concerning temporary and occasional workers. These are defined as workers who depend for their livelihood mainly upon wages, but who, by reason of the nature of their work or by agreement, are not bound to an employer for a certain period. They include:

- (1) transport workers;
- (2) building workers,
- (3) persons employed in public works,
- (4) washerwomen and charwomen who work for several employers, and
- (5) other workers who carry out for remuneration different temporary or casual work for an employer.

An Order opening voluntary insurance to the owners of small-scale undertakings was issued on 2 June 1923 by the Minister of Social Welfare.

Exclusion and Exemption

The Code expressly excludes (1) persons employed in agricultural undertakings; (2) persons employed on board vessels making long voyages, and (3) persons on active military service (section 1, note 1).

Further, the Ministry of Labour may exempt: (1) undertakings of a temporary character, (2) undertakings employing less than 200 persons which, by reason of their isolated situation, cannot be associated with another undertaking for the purpose of forming a sickness fund, in this case, the exemption lasts only until the difficulty can be overcome (sections 10 and 11), and (3) civil servants entitled to equivalent treatment.

LITHUANIA

COMPULSORY INSURANCE

General Formula

The Lithuanian Act of 9 December 1925, which was amended on 28 September 1926, renders insurance compulsory for all persons, irrespective of age or sex, who are engaged for work or employment by the State, the municipalities or private persons (section 12).

Unpaid apprentices are assimilated to wage-earners in the lowest wage-class (section 97).

Exclusion

The following categories of workers are excluded from compulsory insurance:

- (1) agricultural workers;
- (2) persons insured in virtue of the Act concerning pensions and assistance for State civil servants,
- (3) casual workers whose employment lasts less than a month (section 13 (1));
- (4) persons whose monthly remuneration exceeds 400 litas (section 13 (2)); and
- (5) independent workers.

VOLUNTARY INSURANCE

The Lithuanian Act prescribes different conditions of admission and of contribution according as the applicant is or is not an agricultural worker.

Agricultural workers are entitled to insure voluntarily and, should they so insure, their employers and the State are required to pay the same contributions and in general to carry out the same obligations towards such

workers as to workers in industries subject to compulsory insurance (section 14).

For other persons not covered by compulsory insurance, voluntary insurance is open, provided that they are not over the age of 50, and that they do not suffer from a predisposition to disease. Such persons may not insure in respect of an income exceeding 6,000 litas, plus 1,000 litas in respect of each dependent child (section 15).

LUXEMBURG

COMPULSORY INSURANCE

The Act of 17 December 1925 institutes compulsory insurance for the following classes of workers:

- (1) workers, assistants, journeymen, and apprentices;
- (2) servants and labourers who are employed part-time but regularly in the commercial or industrial undertakings of their employers;
- (3) farm servants and labourers who are regularly employed in undertakings accessory to agriculture; and
- (4) works officials, foremen, technical employees, commercial assistants and apprentices.

It is provided that such workers (with the exception of apprentices) must be employed for remuneration and that the employment must be their principal occupation. Workers in class (4) are not liable to insurance if their annual income exceeds 10,000 francs (section 1).

Exclusion and Exemption

The following classes are expressly excluded:

- (1) established civil servants of the State or local Government;
- (2) members of religious orders;
- (3) members of liberal professions;
- (4) persons whose employment is likely to last less than a week;
- (5) domestic servants and agricultural workers, except as provided above; and
- (6) persons being trained in undertakings belonging to the State or local government (section 3).

Non-manual workers whose annual income exceeds 10,000 francs are, as already mentioned, excluded.

Home Workers

Home workers and independent workers are not at present insured, but the Act provides that they may be brought into insurance by Order (section 2).

Equivalent Treatment

Exemption from compulsory insurance may be granted, on the application of the employer, in respect of non-manual workers who are entitled to the continuance of their pay in case of sickness or otherwise and are guaranteed treatment equivalent to that prescribed by the Act.

VOLUNTARY INSURANCE

The opportunity of insuring voluntarily is offered to the following classes:

- (1) persons for whom insurance would ordinarily be compulsory (section 1) but who are exempted;
- (2) members of the employer's family;
- (3) home workers and independent workers who employ not more than two assistants subject to insurance; and

- (4) domestic servants and agricultural workers, under conditions to be prescribed.

Their income, however, must not exceed 12,500 francs a year, and admission by the insurance institution may be subject to an age limit and the production of a health certificate.

It may also be prescribed that certain classes excluded from compulsory insurance shall be entitled to insure voluntarily (section 5)

Statistics

GENERAL STATISTICS OF THE POPULATION

The population legally domiciled in Luxemburg was 267,447 in 1916. It had fallen in 1922 to 262,684, of which number 132,082 were men and 130,602 were women. There are no recent occupational statistics.

STATISTICS OF INSURED PERSONS

The present Act was promulgated on 17 December 1925, and consequently no statistics relating to its operation have yet been published. The available statistics concern the operation of the Act of 1901, as amended in 1918 and 1919, which applied only to persons employed in certain prescribed undertakings. However, an inspection of the list of undertakings prescribed shows that it includes transport, mining, post office, factories, building, commerce, handicrafts, undertakings using mechanical power, and home workers. Hence the scope of the old Act was substantially the same as that of the new, being merely defined in different terms. The income limit has been raised from 3,000 to 10,000 francs, but this barely compensates for the depreciation of money.

The following table shows the total number of insured persons under the old Act, and their distribution by sex and according as compulsorily or voluntarily insured:

Year	Number of insured persons				
	Total	Men	Women	Compulsorily	Voluntarily
1913	44,040	40,876	3,164	43,202	838
1919	37,719	34,582	3,137	36,801	918
1920	38,442	35,045	3,397	37,495	947
1921	38,359	34,941	3,418	37,353	1,006
1922	43,514	39,683	3,831	42,554	960
1923	47,174	42,802	4,372	46,373	801

Insured persons represented 16.6 per cent. of the total population in 1922.

NORWAY

COMPULSORY INSURANCE

General Formula

By the Sickness Insurance Act of 6 August 1915, insurance is made compulsory for all wage-earners employed in the Kingdom of Norway, as well as employees in public or private service, after they have completed their 15th year of age (section 1 (1)).

The term "wage-earner" is taken to include servants and peasants who work for masters, even if they do not receive money wages, share fishermen, and unpaid apprentices (section 2).

Home Workers

Home workers are also liable to insurance, provided that they are permanently engaged by an employer who supplies the materials. Moreover, if the home work consists in delivering ready to order goods made with materials supplied by the worker, insurance is also compulsory.

Exclusion and Exemption

The following persons are excluded from the scope of the Act.

- (a) non-manual workers whose total annual income exceeds 6,000 crowns,
- (b) persons who are regularly employed on a ship in foreign trade, unless the voyages are limited to fixed routes, and are not expected, in accordance with the published times of sailing, to last more than ten days out from a Norwegian port and back;
- (c) persons for whom sickness benefits are provided in connection with their employment within the Kingdom, in pursuance of any foreign law;
- (d) persons who perform work for communes or other charitable institutions under conditions which give the remuneration the character of relief, and
- (e) persons who are in the service of an ambassador of a foreign power or consul (section 1 (2)).

Temporary Workers

Persons whose conditions of work or service are such that, from the nature of the case, it cannot last as long as six days are not required to be insured (section 1 (3)).

Children living at home who work in the home without a money wage fixed in advance are excluded from compulsory insurance.

At the request of the persons concerned, a sickness fund may exempt from insurance a person whose earning capacity is seriously impaired as a result of chronic illness or other permanent defects or infirmities (section 1 (4)).

VOLUNTARY INSURANCE

Continued Insurance for Persons Previously Insured Compulsorily

Persons formerly subject to compulsory insurance are entitled to be admitted to voluntary insurance, whatever their income, and without medical certificate, if they have been members of a district sickness fund for at least three months immediately prior to the cessation of their liability to insure. Persons excluded from compulsory insurance in virtue of the provisions of section 1, subsection (2), par. (a) to (e), are, however, not entitled to this privilege (section 10 (3)). The application to become a voluntary member must be made not later than one week after the cessation of liability to insurance.

Voluntary Insurance for Persons Outside the Scope of Compulsory Insurance

Every person having completed his fiftieth year, and who does not come under the exceptions provided under section 1 subsection (2), pars. (b) to (d), has the right to be insured as a voluntary member of the local sickness fund, provided that

- (a) his total annual income, including that of his wife (husband) does not exceed 6,000 crowns;
- (b) he produces a medical certificate of good health for himself and his dependants,
- (c) he and his dependants shall not be entitled to compensation during the first four weeks after admittance,
- (d) if he is over 50 years of age at the time of joining, he must pay supplementary contributions for the period since he completed his fiftieth year.

Statistics

GENERAL AND OCCUPATIONAL STATISTICS OF THE POPULATION

At the last Census, taken in 1920, the population of Norway numbered 2,649,775. The population in 1925 was estimated at 2,772,414.

The occupied population aged 15 years and upwards numbered 1,069,960 in 1920; this figure does not include 547,704 wives and daughters looking after the home.

The employed population in 1920 consisted of 564,463 wage-earners and 144,355 salaried employees, or 708,818 in all.

STATISTICS OF INSURED PERSONS

Number of Insured Persons

The total number of persons insured under the Act of 6 August 1915, i.e. the membership of both district and substitute funds, was 584,630 in 1920 and 611,095 in 1925. Teachers and railwaymen are insured under special schemes.

The figures given below refer to the membership of district sick funds, to which belong 96-97 per cent. of the total number of persons insured under the 1915 Act, and are averages based upon the returns made by each fund of its membership at the end of each month.

Year	Number of insured persons	Year	Number of insured persons
1912	330,000	1919	543,124
1913	337,620	1920	558,661
1914	340,619	1921	548,250
1915	351,217	1922	570,524
1916	429,878	1923	579,314
1917	473,439	1924	584,800
1918	520,657	1925	596,184

The principal, but not the only, cause of the increase in numbers since 1912 is the raising of the annual income limit, by a series of amendments, from 1,200 crowns (country) and 1,400 crowns (town) in 1912 up to 6,000 crowns in 1921, from which date only non-manual workers are subject to the restriction. A second cause is the growing efficiency of the supervisory machinery which enforces compliance. The temporary drop in 1921 is due to unemployment.

Compulsory and Voluntary Membership

The relative importance of the compulsory and voluntary membership of the district sickness funds is indicated in the following table:

Year	Compulsory membership		Voluntary membership	
	Absolute in thousands	Per cent	Absolute in thousands	Per cent.
1913	335	99.1	3	0.9
1914	337	98.9	4	1.1
1915	347	98.7	4	1.3
1916	423	98.4	7	1.6
1917	462	97.5	12	2.5
1918	500	96.1	20	3.9
1919	511	94.0	33	6.0
1920	518	92.8	40	7.2
1921	495	90.3	53	9.7
1922	511	89.6	59	10.4
1923	520	89.7	59	10.3
1924	522	89.3	62	10.7
1925	528	88.6	68	11.4

The steady increase in the number of voluntary members is to be explained by measures taken by the Act of 1915 to facilitate access to voluntary insurance, and partly by the active propaganda of sickness funds, and partly, since 1921, by the maintenance of the unemployed as members, the part or whole of the contribution being paid by the municipality and the State.

Distribution of Insured Persons by Sex

The proportion of men and women in the district sickness funds is shown in the following table:

Year	Men		Women	
	Absolute in thousands	Per cent.	Absolute in thousands	Per cent
1912	194	58.9	136	41.1
1913	201	59.6	136	40.4
1914	202	59.2	139	40.8
1915	207	58.8	145	41.2
1916	257	59.8	173	40.2
1917	289	61.1	184	38.9
1918	328	63.0	193	37.0
1919	343	63.1	200	36.9
1920	355	63.6	204	36.4
1921	344	62.8	204	37.2
1922	359	62.9	212	37.1
1923	367	63.4	212	36.6
1924	369	63.1	216	36.9
1925	374	62.7	222	37.3

Relation of Insured to Occupied and Total Population

Relation of insured (district fund membership) to total population.

$$\text{in 1920, } \frac{558,661}{2,649,775} = 21.3 \text{ per cent.}$$

$$\text{in 1925, } \frac{596,184}{2,772,414} = 21.6 \text{ per cent.}$$

Relation of insured to occupied population,

$$\text{in 1920, } \frac{558,661}{1,069,960} = 55 \text{ per cent.}$$

Relation of compulsorily insured (district fund membership) to wage-earning population,

$$\text{in 1920, } \frac{518,265}{708,818} = 73 \text{ per cent.}$$

POLAND

COMPULSORY INSURANCE

According to the Act of 19 May 1920, insurance is compulsory for every person irrespective of sex who is engaged as a wage-earner, employee, or who gives his services for remuneration, and in particular for:

workmen, assistants, journeymen, apprentices, improvers, foremen, supervisors, engine-men, office and technical employees and officials, managers and managing officials in industry, handicrafts, mines, commerce and communications;

employees in banks, commercial and technical establishments, shops, warehouses, eating houses, hotels, pharmacies, offices, publishing houses, newspaper offices, also employees connected with public displays and orchestras, and with social, religious, philanthropic and public institutions and associations of all kinds;
 persons employed in undertakings owned by the State and by local authorities and also the wage-earning and salaried employees employed by them;
 workers on railways and other transport undertakings, the crews of vessels and other means of transport by water;
 permanent and seasonal workers in agriculture and forestry;
 workers, teachers and tutors in all establishments for instruction and education; and
 domestic servants (section 3).

Temporary and Home Workers

In addition, insurance is compulsory for temporary workers, home workers and persons working in association with home workers (section 3).

For the purposes of the Act, a temporary worker means any person the hiring out of whose services constitutes his principal means of subsistence and who is not bound by a permanent contract of work with a single employer but who works for an employer for less than six consecutive days at a time (section 7).

Further, a home worker is any person working either in his own place of residence or in a workshop solely or mainly on account of one or more employers, even if he furnishes his own materials and tools, and employs members of his family or other workers, provided that such home work constitutes his principal means of subsistence (section 6).

Unpaid Apprentices

Improvers and apprentices of all kinds are subject to insurance even if they receive no wages (section 5 (3)).

Foreigners

The principal Act of 1920 makes no distinction between the treatment of nationals and foreigners. A special Act was, however, passed in 1923 which enabled retaliatory measures to be exercised against subjects of foreign States which do not accord equality of treatment to Polish nationals residing within their territory.

Exclusion and Exemption

In principle, all employed persons in Poland are subject to compulsory insurance, there being no limits in respect of occupation, earnings or age. Nevertheless, during a transitional period the majority of agricultural workers remain uncovered by insurance. At the present time one may say that the insurance of agricultural workers hardly exists outside the former Prussian territory and Upper Silesia.

Exemption is allowed on the application of the person concerned in the case of the immediate representatives of the owners of industrial undertakings whose salary exceeds 7,500 zloty a year (section 4).

State officials nominated to appointment and not engaged under a contract of work are not liable to compulsory insurance. Nevertheless, they are provided with medical benefit under a special scheme. The situation of workers on the State railways is similar.

VOLUNTARY INSURANCE

Continued Insurance for Persons Previously Insured Compulsorily

Persons formerly subject to compulsory insurance are entitled unconditionally within four weeks after cessation of their employment to become insured as volunteers.

Voluntary Insurance for Persons Outside the Scope of Compulsory Insurance

Any person not subject to compulsory insurance may become a voluntary member of a sickness fund provided that he is under 45 years of age and that his total yearly income does not exceed 7,500 zloty.

Statistics

GENERAL AND OCCUPATIONAL STATISTICS OF THE POPULATION

According to statistics supplied by the Polish Government, the population of Poland on 1 January 1926 was estimated at 29,249,000.

There are no official figures of the number of the occupied population, but unofficially it has been estimated at 8,970,000 (Weinfeld: *La Pologne — Tableaux statistiques*, Warsaw, 1925) or 33 per cent. of the total population.

The same author considers that the population draws its livelihood from the various occupations in the following proportions:

Occupation	Per 100 inhabitants
Agriculture and forestry	65
Industry and mining	14
Commerce and communications	8
Other occupations	13

According to statistics supplied by the Polish Government, the employed population in 1926 was estimated at 4,620,000.

STATISTICS OF INSURED PERSONS

Number of Insured Persons

As the Act was not put into force in the former Russian territory of Poland until 1922, statistics relating to previous years are not comparable with those relating to subsequent years.

The total number of insured persons in Poland (excluding Upper Silesia) is shown in the following table, a distinction being made between compulsory and voluntary insurance.

Year (1 January)	Compulsory insurance	Voluntary insurance	Index No.
1923	1,415,798	—	100
1924	1,602,345	1,932	113
1925	1,653,316	1,964	117
1926	1,777,426	2,001	126

According to statistics supplied by the Polish Government, the total number of insured persons in Poland (including Upper Silesia) at the beginning of 1926 was 2,052,000, of whom 2,300 were voluntarily insured; thus the insured population of Upper Silesia is about 250,000.

Distribution of Insured Persons by Sex

The next table shows the distribution of the insured population according to sex:

Year	Men		Women (absolute)
	Absolute	Per cent.	
1 July 1923	1,004,722	67.9	474,552
1 January 1924	1,102,189	68.8	500,156

Distribution of Insured Persons by Age

According to information communicated by the Ministry of Labour, the distribution by age of 1,154,529 insured persons belonging in 1924 to funds other than those of Upper Silesia was as follows:

Age group	Per cent of insured persons		
	Men	Women	Both sexes
Up to 15	1.2	1.5	1.3
16-20	14.0	20.7	16.0
21-25	15.8	26.0	18.9
26-30	14.3	16.5	14.9
31-35	11.9	10.4	11.4
36-40	10.0	7.5	9.2
41-45	8.5	5.5	7.6
46-50	7.1	3.8	6.1
51-55	6.0	2.8	5.0
56-60	4.1	1.6	3.3
61-65	2.8	1.1	2.3
66-70	1.5	0.6	1.2
71-75	0.7	0.3	0.6
76-80	0.2	0.1	0.2
Unknown	1.2	0.8	1.1

Dependants Entitled to Benefit

The dependants of insured persons are entitled to benefits in kind. Their numbers were as follows in the last few years:

1 January 1923	1,721,101	or 1.09	per insured person
1924	2,116,405	„ 1.32	„ „ „
1925	2,101,539	„ 1.27	„ „ „
1926	2,460,000	„ 1.40	„ „ „

Civil Servants and Railwaymen

The above figures do not include civil servants and persons employed on the State railways, all of whom are provided by the terms of their employment with free medical aid for themselves and their dependants. The number of civil servants and their dependants was 400,000 in 1924, and that of railwaymen 108,148, with 272,738 dependants.

Relation of Insured to Occupied and Total Population

The total population on 1 January 1926 has been estimated at 29.25 millions. On that basis the insured population would represent 7 per cent. of the total.

If the occupied population be taken as 9 millions, then the proportion which is insured is about 23 per cent.

On the assumption that the wage-earning population is 4,270,000 the proportion of wage-earners insured would be 44 per cent. It must be recalled at this point that during a transitional period agricultural workers in former Austrian and Russian Poland are not subject to insurance, and that these workers represent a large proportion of all wage-earners.

ROUMANIA**Former Kingdom and Bessarabia****COMPULSORY INSURANCE**

Sickness insurance in pre-war Roumania and Bessarabia is regulated by the Act of 25 January 1912. Insurance is compulsory for masters, journey-

men and apprentices occupied in any handicraft (section 1), for rural craftsmen who employ assistants or apprentices and for apprentices and workers in factories, mines and quarries (section 2). The scope of the Act thus includes employers who are masters of a craft, and masters working on their own account, as well as wage-earners. Apprentices are included even if they receive no wages.

Exclusion

The Act does not cover workers in agriculture, commerce, or transport, nor domestic servants.

Ardeal

Ardeal possesses a sickness insurance scheme established by the Hungarian Act No. XIX of 1907 (see Hungary). This Act, however, did not apply to agricultural workers, but this defect has been remedied by a decree issued in 1919. Henceforth all wage-earners in industry, commerce and agriculture without limit of income are made liable to insurance. Non-wage-earners are not obliged to insure.

Bukovina

The legislation in force in Bukovina is derived from that of Austria. Insurance is compulsory for wage-earners in industrial and commercial undertakings without limit of income. Agricultural workers and non-wage-earners are, however, excluded.

Statistics

NUMBER OF INSURED PERSONS AT THE END OF 1924

Occupation	Former Kingdom and Bessarabia	Ardeal	Bukovina	Entire Kingdom
Large-scale industry (more than 20 workers)	414,000	182,970	10,500	607,470
Small-scale industry (less than 20 workers)	136,000	109,120	19,500	264,620
Commerce		25,813	3,500	29,313
Agriculture		66,262	1,700	67,962
Civil service		17,062	500	17,562
Domestic servants		9,894	300	10,194

(*Buletinul Muncii*, April, May, June, 1926, No. 4/5/6, p. 286.)

RUSSIA

COMPULSORY INSURANCE

General Formula

The scope of sickness insurance in Russia is defined in Chapter XVII of the Labour Code of 9 November 1922. It covers all employed persons irrespective of whether the undertakings, institutions and business in which

they are employed are State, public or co-operative, established under a concession or lease, of mixed character or private, or whether they are employed by private individuals, and also irrespective of the nature and duration of their employment and the method of remuneration (section 175). The scope is more precisely defined in Regulations of the Federal Social Insurance Council, dated 9 May 1927.

Home Workers

Home workers are liable to insurance provided that they employ no assistants (even apprentices) and that they work up materials supplied by a person who trades in the finished article (Order of Council of Commissaries, dated 2 July 1923).

Domestic Servants

Domestic servants are liable to insurance, but as difficulties of interpretation have arisen, special regulations with regard to them have recently been issued (Order of the Central Executive Committee and of the Council of Commissaries, dated 25 September 1925, and Instruction of the Federal Social Insurance Council, dated 31 October 1925).

Exclusion

In agriculture, only undertakings where at least three workers are employed for at least one year are subject to insurance, in accordance with rules made by the Federal Social Insurance Council (para. 14 of Provisional Regulations of the Council of Commissaries, dated 18 April 1925). In accordance with the same Regulations, the farmer in other undertakings is required to pay the worker his wages, in cash and in kind, for one month or two weeks, according to the duration of the employment, while medical aid is provided by the medical service available to insured persons.

Temporary workers and seasonal workers mentioned in special lists, the duration of whose employment is less than one month, are not entitled to benefits in case of temporary incapacity due to illness (List No. 1 in *Insurance Questions*, No. 17, 1927, and List No. 2 in *Izvestia*, No. 22, 1927).

Statistics

GENERAL AND OCCUPATIONAL STATISTICS OF THE POPULATION

According to statistics supplied by the Russian Government, the total population at the Census of 17 December 1926 was 145,906,000, of whom 25,760,000 were town-dwellers and 120,146,000 were peasants.

The total occupied population may be estimated at 74,000,000.

The total number of wage-earners was as follows:

1923-1924.	7,573,800
1924-1925.	8,763,900
1925-1926.	10,545,000

STATISTICS OF INSURED PERSONS

Number of Insured Persons

The number of insured persons has increased rapidly in the last few years:

1 January 1924	5,436,000 ¹
1 October 1924	6,276,000 ²
1 October 1925	7,631,000 ³
1 October 1926	8,795,000 ³

¹ *Labour Statistics*, 1925, No. 2.

² CENTRAL DEPARTMENT OF SOCIAL INSURANCE: *Statistics for 1924-1925*, p. 2.

³ *Statistics of Labour and Social Insurance, 1925-1926*, p. 46.

Distribution by Sex

According to the social insurance statistics for 1924-1925¹, the distribution according to sex was as follows in that period:

		Per cent.	
		Men	Women
1 October 1924		76.52	23.48
1 January 1925		75.96	24.04
1 April 1925		75.71	24.29
1 July 1925		74.43	25.57
1 October 1925		76.22	23.78

Relation of Insured to Occupied and Total Population

- (i) Insured persons form 6 per cent of the total population.
- (ii) Insured persons form 12 per cent of the occupied population
- (iii) Insured persons form 83 per cent. of the wage-earning population.

It must be remembered, in interpreting the above statistics, that of the 140 million inhabitants of Russia, only 6 or 7 million are urban wage-earners. The remainder are almost entirely non-wage-earning peasants, who are not liable to insurance

SERB-CROAT-SLOVENE KINGDOM

COMPULSORY INSURANCE

General Formula

Insurance is compulsory, in virtue of the Act of 14 May 1922, for every person who performs physical or mental work for remuneration within the territory of the Kingdom, either permanently or temporarily, irrespective of the terms of employment, and without distinction of sex, age or nationality (section 3).

Apprentices

There are included among the persons subject to insurance apprentices, voluntary workers, pupils in workplaces belonging to public educational institutions (craft and technical schools, etc) and likewise persons who receive no salary or wages or whose pay is less than the customary rates (section 3 (2)).

Home Workers and Small Masters

The scope of insurance also includes any person engaged in work for wages in his own workplace or dwelling by order and on account of another person carrying on a handicraft, commercial business or industry, even if he procures the raw materials and accessories himself, and also does work on his own account (section 3 (3)).

Every person engaged in home industry is likewise liable to insurance under special conditions (section 3 (6)).

Shipping and Sea Fishing

In the shipping industry all members of the crews of national vessels and all persons engaged in sea fishing by way of trade are liable to insurance, even if resident abroad (section 3 (4)).

On seagoing vessels with a gross tonnage of not more than 50 tons which cannot be propelled by steam or mechanical power but work independently, the employer is also liable to insurance if he is a member of the vessel's crew. Employers on vessels engaged in sea-fishing are likewise liable to insurance in every case where the vessel has no steam or mechanical motive power or only an auxiliary engine, and the employer is a member of the crew (section 3 (5)).

¹ CENTRAL DEPARTMENT OF SOCIAL INSURANCE. *Statistics for 1924-1925*. p. 4.

National Workers Residing Abroad

National workers permanently or temporarily employed abroad by a national undertaking are liable to insurance if they are not already insured under the legislation of the State in the territory of which they are employed (section 8 (1) and (2)).

Foreign Workers

An alien employed within the Kingdom is treated on an equality with nationals of the Kingdom. The Minister of Social Affairs may issue special provisions concerning nationals of States which possess social insurance systems, but which do not treat nationals of the Kingdom employed there on an equality with their own nationals (section 8 (3)).

Exemption

Provisional Exemption

The following classes of persons are provisionally exempt from liability to insurance:

- (1) agricultural workers, and farm servants engaged in agriculture;
- (2) persons occasionally and temporarily engaged in household tasks, such as daily workers engaged to work in the garden, clean the house, chop wood, do washing, etc ;
- (3) persons engaged in sea fishing;
- (4) persons engaged in home industry.

These four classes of workers are to be insured under conditions to be prescribed by the Minister of Social Affairs. The decrees containing the special provisions have not yet been issued, however, so that in fact at the present time liability to insurance applies only to workers in industry and commerce.

Conditional Exemption

Public servants. — The staff of transport undertakings belonging to the State is exempt from liability to insurance provided that the Minister of Transport guarantees equivalent benefits.

The Decree of 30 May 1922 concerning the insurance of the staff of State transport undertakings provides for persons employed under the Ministry of Transport and the managements of State and other railways and the shipping department advantages substantially equivalent to those offered by the Act of 14 May 1922, these workers are in consequence exempt from liability to insurance (section 6 (5)).

Persons who are employed in offices, institutions or undertakings belonging to the State, a province, a county, a district, a town, a commune, a parish, an association of joint owners, an association founded under the Water Act, or any other public body, institution or foundation, are exempt from liability to insurance provided that they receive their wages for at least 26 weeks from the beginning of the illness in virtue of the service regulations applying to them.

The workers exempt in virtue of the above provision are entitled, together with their families, to medical attendance and likewise to maternity and funeral benefit (section 7 (1) and (3)).

The position of civil servants and other persons employed in the public services is regulated by the Act of 31 October 1923. In accordance with this law established civil servants are exempt from liability to insurance, while persons engaged in virtue of a contract and not by appointment remain subject to insurance.

Occasional and temporary workers. — The Minister of Social Affairs may, on the proposal of the insurance institution, exempt any persons who become liable to insurance only at intervals on account of occasional and temporary employment for wages (section 4).

VOLUNTARY INSURANCE

Any person not liable to compulsory insurance may insure himself voluntarily (section 5).

The conditions under which persons may be admitted in voluntary insurance are prescribed in an Order dated 3 June 1922.

The following classes of persons in particular are entitled to insure: civil servants and persons employed by public bodies, intermittent workers, small masters engaged in home industry, and persons engaged in sea-fishing. Applicants must pass a medical examination and they must not be over the age of 40 years. The whole contribution is paid by the insured person.

Statistics

GENERAL STATISTICS OF THE POPULATION

The Serb-Croat-Slovene Kingdom has a population of 12,017,323, or 48.8 inhabitants per square kilometre.

No information as to the size of the occupied population is available.

STATISTICS OF INSURED PERSONS

Number of Insured Persons

The number of persons compulsorily insured each year since the Act was put into operation in July 1922 is shown in the following table:

Date	Compulsorily insured persons	Index No
1 July 1922	400,709	100
1 January 1923	391,219	97.6
1 January 1924	449,204	112.1
1 January 1925	453,583	113.2
March 1926	458,504	114.2

There were at the end of 1925 only 2,799 persons who had insured voluntarily.

The above figures include neither miners nor persons engaged in State transport undertakings, who are insured in independent institutions; and who number about 90,000.

Distribution of Insured Persons by Sex

The proportion of men to women among insured persons has been as follows in the last few years:

1 January 1924	80.6	per cent. men
1 January 1925	79.66	" " "
March 1926	76.84	" " "

Dependants Entitled to Benefit

The immediate relatives of the insured person living with him are entitled to medical aid. The number of dependants entitled to this privilege is not available.

Relation of Insured to the Total Population

The proportion of insured to the total population is about $4\frac{1}{2}$ per cent., not including dependants entitled to benefit.

CHAPTER II

**COMPULSORY INSURANCE OF WORKERS OF SMALL MEANS,
AND POPULAR INSURANCE**

Liability under the compulsory insurance schemes described in the previous Chapter is determined chiefly by the existence of a contract of service, so that their scope is confined in the main to wage-earners and only exceptionally includes small numbers of other classes.

In recent years there has been developed in several countries another type of compulsory insurance scheme which disregards the contract of service as a criterion and defines its scope by reference to the economic strength and security of the various classes of the population and is therefore not confined to wage-earners.

Consideration of the economic strength of the individual rather than of his status as worker characterises the Portuguese and Chilean legislation, and that of the Swiss Cantons of Appenzell (Outer and Inner Rhodes), Basle Town, St. Gall, and Thurgau.

While, however, the legislation of the Swiss Cantons makes persons of small means liable to insurance irrespective of their work, the Portuguese and Chilean laws apply only to persons who are engaged in gainful activity. The fact that these criteria are different has, however, little practical importance, since all persons lacking sufficient independent means are practically obliged to follow an occupation as a means of livelihood.

§ 1. — Compulsory Insurance of Workers of Small Means

PORTUGAL

(Act No. 5,636 of 10 May 1919)

The Portuguese law makes insurance compulsory for individuals of both sexes who exercise any occupation within the domain of human activity which is recognised as worthy and honest by usage and custom and sanctioned by the law (section 1).

The sweeping generality of the terms of this formula must not deceive the reader as to the real range of the law and as to the

nature of the persons actually insured. As a matter of fact, although the status of the worker as independent or dependent is without importance, yet account is taken of means, and this criterion is used in order to divide the persons covered into two groups: that of persons actually insured and that of "born" insured, viz.:

(i) Persons of both sexes between the ages of 15 and 75 who do not possess an annual income or wage higher than 900 escudos are actually insured (*socio efectivo*); they pay contributions and are entitled to benefits in case of sickness (section 3).

(ii) Landlords, military, civil and administrative officials, merchants, shopkeepers, manufacturers and persons who live upon dividends, if they enjoy an annual income higher than 900 escudos, constitute the group "born" insured (*socio nato*); they pay contributions but have no right to benefit in case of sickness (section 4).

Persons belonging to the first group alone can be regarded as genuinely insured, so that the Portuguese scheme is an example of the insurance of workers of small means, whether dependent or independent.

CHILE

(Act No. 4,054, of 8 September 1924, concerning Compulsory Insurance against Sickness and Invalidity; Final Text as established by Decree No. 34 of 22 January 1926)

The Chilean Act sets up compulsory insurance for wage-earners and independent workers of small means, together with a complementary system of voluntary insurance.

Compulsory Insurance

The following classes of persons are liable to compulsory insurance:

(a) Wage-earners of both sexes under the age of 65 who ordinarily have no revenue or means of subsistence other than the wage or salary paid to them by their employers, provided that the wage or salary does not exceed 8,000 pesos a year (section 1 (1)).

(b) Probationers or apprentices even if they receive no remuneration (section 1 (2)).

(c) Artisans or craftsmen who work on their own account, those who exercise a skilled trade, or who perform services directly for the public in the streets, public gardens and other public places; small manufacturers and small trades whether itinerant or not, if their annual income does not exceed 8,000 pesos (section 1 (3)).

Liability to insurance is determined by reference not only to earnings but to annual income from whatever source, e.g. pensions, income from property (section 4 (1)).

If the salary or wages are paid partly in cash and partly in food, lodging, cultivable land or any other similar consideration, the part which is paid in kind is to be valued in money (section 4 (2)).

Persons belonging to an approved mutual benefit society which provides for its members benefits at least equal to those specified in the Act are exempt from liability to insurance (section 1 (4)).

Voluntary Insurance

Voluntary insurance is open to three classes of persons, namely, persons not subject to compulsory insurance, persons formerly subject to compulsory insurance, and members of the insured person's family.

(a) Persons not subject to compulsory insurance who are under the age of 45 and whose income does not exceed 8,000 pesos a year may insure voluntarily if they obtain a satisfactory medical certificate from a doctor appointed by the insurance institution (section 3).

(b) Persons who have been compulsorily insured but whose income has exceeded the limit of 8,000 pesos may continue in insurance as volunteers as long as their annual income does not rise above 16,000 pesos (section 5).

(c) Insured persons may, on paying an additional contribution, extend the benefits of medical attendance and drugs to the members of their family, that is to say, to the wife (husband), legitimate children, illegitimate children legally recognised, parents, and in general, all persons whom the insured person is legally bound to maintain. Nevertheless, these persons are not entitled to insurance benefits unless they live with the insured person at his expense except in the case of parents who are not themselves liable to insurance (section 13).

Year	Total population	Statistics of insured persons			Total number of insured as per cent. of total population
		Number of insured			
		Compuls- only	Volunt- only	Total	
1925	3,944,142	342,500	3,718	346,218	8.8
1926	4,000,000	496,700	16,533	513,233	12.8
1927	—	650,000	23,718	673,718	—

§ 2. — Compulsory Popular Insurance in Certain Swiss Cantons

DEVELOPMENT OF COMPULSORY SICKNESS INSURANCE

In Switzerland the Federal Act of 13 June 1911 introduced compulsory insurance against industrial accidents but did not make insurance obligatory in case of sickness. The Confederation has confined its efforts to the encouragement of voluntary sickness insurance by granting subsidies to approved sickness funds.

Section 2 of the Federal Act, however, provides that the Cantons may render insurance against sickness compulsory for the whole or a part of the population and that the Cantons may delegate this privilege to the communes.

The Cantons which have made use of the power of making sickness insurance compulsory may be divided into two groups:

- (i) the Cantons of Appenzell (Outer Rhodes), Appenzell (Inner Rhodes), Basle Town, St. Gall, and Thurgau have set up a cantonal scheme of compulsory sickness insurance covering more or less extensive groups of operation; and
- (ii) the Cantons of Berne, Fribourg, Grisons, Lucerne, Schwytz, Ticino, Unterwald (Nidwald, Obwald), and Uri have delegated their powers to the communes. The same is the case in the Cantons of Schaffhausen and Zurich where laws, dated 10 May and 6 June 1926, prescribe the principles to be followed by the communes which take advantage of the option granted to them of applying compulsory insurance.

Compulsory sickness insurance for schoolchildren on a cantonal basis has been established in the Cantons of Fribourg, Geneva, and Vaud, and upon a communal basis in the Cantons of Soleure and Valais. In this report only the schemes of compulsory sickness insurance for adults which have been directly established by the cantons themselves, i.e. the first group, will be taken into consideration.

CHARACTER OF COMPULSORY INSURANCE

Compulsory insurance in the Swiss Cantons is of a popular character: it applies to persons of small means irrespective of their status as workers and the nature of their occupation. The essential criterion for determining their liability to insurance is the amount of their resources. This criterion, however, does not

apply to persons in temporary residence, who are liable to insurance regardless of their means.

The means limit is fixed according to the amount of the capital or annual income subject to taxation in the Cantons of Appenzell (Outer and Inner Rhodes), St. Gall, and Thurgau, and according to annual income only in the Canton of Basle Town. The means limits vary widely in the different Cantons, as appears from the following table:

Canton	Annual income limit	
	For a single person	For a family
St. Gall	300	300
Appenzell (Inner Rhodes) . . .	1,200	2,000
„ (Outer Rhodes) . . .	2,100	2,100
Basle Town.	4,500	6,000 + 500 per child
Thurgau (when capital is less than 5,000 francs).	3,500	3,500

In the Cantons of St. Gall and Appenzell (Outer Rhodes) the law makes special provision for the case of children having a joint household with their parents.

This variety is doubtless due in the first place to the degree of influence of the idea of social insurance, but may also be explained by the diversity of the cantonal rules concerning taxable income, and still more by the inequalities in the standard of living in the different Cantons.

CANTON OF APPENZELL, INNER RHODES

(Order of 29 November 1920)

The following classes of persons are subject to compulsory insurance and are bound to join a public sickness insurance fund if they are not already insured with a private fund:

(1) All persons in temporary residence (*Aufenthalter*)
 (2) All persons domiciled in the Canton who are over the age of 14 and have not reached the age of 60, whose means do not exceed 10,000 francs in the case of a bachelor, a widower, a widow with children, or a married couple; or whose annual income from capital and earnings does not exceed 2,000 francs in the case of a married couple, a widower or a widow with children, and 1,200 francs in the case of a bachelor, a widower, or a widow without children

(3) Girls and boys over the age of 14 living in their parents' house, provided that the latter are subject to compulsory insurance.

Insurance remains compulsory for persons over the age of 60 in the case of persons who had already been insured before reaching that age (section 3).

The following classes of persons are not subject to insurance:

- (a) the inmates of charitable institutions,
- (b) persons suffering from an incurable disease, and
- (c) the pupils of private institutions.

CANTON OF APPENZELL, OUTER RHODES

(Act of 30 April 1916 and Order of 30 May 1924)

Sickness insurance is compulsory for all temporary residents within the territory of the Canton (Act, section 1). The term "temporary resident" means any person of either sex living in the Canton who is not a burgher of the commune which he inhabits, and, in accordance with the legislation in force, is not bound to obtain permission to establish himself permanently (Order, section 1).

Moreover, the Act authorises the communes to render sickness insurance compulsory for other classes of persons (section 2). The Order (section 2) defines these persons in the following manner:

(1) Persons of either sex who are in their eighteenth year at the beginning of the civil year, and who pay neither a tax on capital nor the income tax, and persons who appear in the tax register as possessing not more than 2,100 francs in capital or income. When a married man is subject to compulsory insurance, the latter also covers his wife.

(2) Boys and girls over the age of 14 who live with their parents, or with either parent, on condition that the parents do not appear, according to the tax register, to possess capital or income to the amount of more than 2,100 francs, and on condition that the children concerned are employed in an industrial or commercial undertaking belonging to a third party, or work in the house on account of a third party in return for remuneration.

Liability to insurance does not apply to the inhabitants of the commune who are over the age of 60. Nevertheless, even after they have reached that age, persons who previously had been insured continue to be subject to insurance.

By decision of the commune persons suffering from incurable diseases may be exempted from insurance (Order, section 3).

The sickness funds may make a rule whereby admission is refused to persons who, by reason of physical or mental infirmity, are unable to earn their living.

The public sickness fund may prescribe that persons suffering from a disease necessitating immediately, or in the near future, the assistance of the fund, shall only be admitted under certain conditions. In cases of this kind no insurance benefit will be granted by the fund on account of disabilities declared to exist by the doctor in his certificate. This restriction is removed on the expiration of two years, or even sooner, if the insured person proves, by means of a medical certificate, that the disability on account of which the admission was subject to this condition no longer exists.

The fund has the right to require from persons admitted to it a medical certificate, although insurance is compulsory (Order, section 27).

The commune may decide to exempt from liability to insurance the inmates of asylums, persons in receipt of poor relief, the inmates of prisons, and the pupils of private institutions.

CANTON OF BASEL TOWN

(Acts of 12 March and 19 November 1914, amended by the Act of 23 February 1922)

Sickness insurance is declared to be compulsory:

- (a) for families whose total annual income does not exceed 6,000 francs; and
- (b) for persons living alone whose total annual income does not exceed 4,500 francs.

The total annual income means annual taxable income, less 500 francs for each minor child. Children are considered as minors until the expiration of the year in the course of which they complete their fourteenth year of age.

Liability to insure only applies to persons who have not reached the age of 60 at the time when the Act of 19 November 1914 was put into force.

The following are exempt from liability:

- (a) the inmates of institutions;
- (b) persons who live in the household either of their own family or of their employer, when the total income of the family or the employer exceeds 6,000 francs. (Act of 19 November 1914, section 1.)

The State Council may by Order exempt from compulsion to insure persons already insured in virtue of legislation other than that of the Canton, or who, by reason of their conditions of work, are members of the sickness fund of an establishment).

CANTON OF SAINT GALL

(Act of 28 May 1914, amended by Act of 28 November 1919)

The following are subject to compulsory insurance against sickness:

- (1) Persons of either sex who are in temporary residence.
- (2) Children brought up by private persons in accordance with the provisions of the Act concerning the assistance and education of poor children and orphans.
- (3) Other inhabitants of the commune, of either sex, who, according to the tax register of the State, are not subject to the tax on capital, and whose taxable income does not exceed 300 francs, provided that such inhabitants were over the age of 18 at the commencement of the civil year (section 1).

Boys or girls living in the household of one or both parents are not liable to insurance, provided that such parents appear in the State tax register as possessing taxable capital or a taxable income of more than 300 francs. Boys and girls who, by the preceding provisions, would be exempted from liability to insure, are nevertheless insurable as long as they are employed in an industrial or commercial undertaking belonging to a third party.

Liability to insurance ceases with the completion of the sixtieth year. Nevertheless, persons who were already compulsorily insured at the time when they completed their sixtieth year remain subject to the said liability as long as they fulfil the conditions of residence prescribed by section 1, or are inhabitants of the commune not exempted by reason of their being subject to taxation.

These provisions apply even when the person concerned moves from one commune to another within the Canton (section 1). The communal authorities have the right to extend compulsory insurance to other classes of the population. This extension must be decided by a popular assembly and be approved by the State Council and the Federal Council.

The following classes of persons are excluded from the communal sickness funds

- (1) The inmates of prisons
- (2) The inmates of workhouses.
- (3) The inmates of hospitals and public asylums.
- (4) Persons seeking admission who are over the age of 60.
- (5) Persons residing in the commune who are insured with another private fund in respect of all sickness benefits.
- (6) Persons who are excluded from a fund by reason of their mode of living, or their dishonest claims to benefit
- (7) Persons who cannot provide for themselves by reason of physical or mental infirmity, or who suffer from infirmities or diseases of such a kind as to make assistance from the fund necessary immediately or in a short time.
- (8) Persons whose situation in case of sickness is such that their membership of the fund would be a source of profit (section 20).

The reasons for exclusion mentioned in (4) and (7) above cannot be brought forward in case of persons who are making use of their right of free passage from one private approved fund to another, or passing from one communal fund to another.

Exemption from liability to insurance may be prescribed in the case of inmates of institutions, persons in hospitals, and the manual and non-manual workers employed in undertakings which guarantee to provide the benefits of the communal fund in case of sickness, and are offered sufficient security that their obligations will be carried out. Exemption in this case is granted on the application of the parties concerned by the State Council acting on the advice of the municipal council.

The inmates of private institutions may also be exempted, in this case the exemption is granted by the municipal council, whose action, however, requires the approval of the State Council.

CANTON OF THURGAU

(Act of 24 April 1926)

The following classes of persons are liable to insurance against sickness and also against accident if the latter risk is not covered by another branch of insurance:

- (1) Persons of either sex who are in temporary residence;
- (2) Persons of either sex in permanent residence or possessing the rights of citizenship who are subject to taxation on income or capital:
 - (a) in respect of capital of less than 15,000 francs when they have no income;
 - (b) in respect of an income of less than 2,500 francs when their capital does not exceed 10,000 francs,
 - (c) in respect of an income of from 2,500 to 3,500 francs when their capital does not exceed 5,000 francs.

Minors and adult children who have no income of their own and who live with their parents, as well as married women, are not liable to insurance when the head of the family pays taxation on a sum exceeding the amount prescribed in paragraphs (a), (b) and (c) above.

Liability to insurance commences with the civil year in the course of which the person concerned enters on his fifteenth year, and ceases with the completion of his sixtieth year. Persons who, on attaining the age of 60, are subject to insurance remain insured.

Municipalities are authorised to extend the scope of insurance to classes of the population other than those prescribed by the Cantonal Act.

Persons who, by reason of physical or mental infirmity, are permanently incapable of earning their living are exempt from liability to insurance. Moreover, the institutions which administer compulsory insurance may exclude from its scope persons suffering from diseases or infirmities which would require benefits to be provided either immediately or in the near future, but such exclusion can apply only in respect of a particular disease or infirmity. Further the institutions may exclude persons who fraudulently claim benefits, or who frequently disobey the rules of the institution as well as persons who, by their mode of living, injure their health.

Compulsorily insured persons living in poorhouses, prisons and reformatories for beggars are not required to pay a contribution and cannot claim benefits as long as they are inmates of these establishments.

CHAPTER III

THE OPERATION OF THE COMPULSORY PRINCIPLE

The ordinary working of the compulsory principle involves the affiliation of every person subject to insurance to an insurance institution, and the payment of the contributions for which he is liable to the institution

Enforcing the principle of compulsion thus entails the adoption of rules for determining on whom the responsibility for compliance with the formalities connected with affiliation and with the payment of contributions rests, and prescribing the consequences of failure to carry them out.

These consequences may affect both the manner in which the risk is covered and the liability of the physical or legal person responsible for carrying out the legal obligation. Failure to comply with the rules concerning affiliation or the payment of contributions rarely has the effect of preventing the risk being actually covered; and most laws stipulate that insurance automatically begins as soon as the provisions of the contract of employment come into force. Failure to join an institution, or to pay contributions, does not in that case deprive the offender of the protection of insurance; and the risk is covered whether legal requirements have been complied with or not. A person is therefore in fact insured as soon as he becomes liable to insurance.

In some cases, however, persons subject to insurance only acquire and retain the status of an insured person when the required formalities connected with membership and the payment of contributions have been accomplished; and thus failure to comply with the legal provisions prevents the risk being covered.

In other cases, acquisition of insured status may be automatic, whilst rights to full benefits are contingent upon the required formalities connected with membership and the payment of contributions.

In all cases, moreover, failure to comply with the rules regarding affiliation and the payment of contributions is a breach of the law, rendering the offender liable to sanctions, independently of any civil liability for the damage caused either to the insurer or the insured. Penal measures are therefore taken to enforce the legal obligations in question, and to ensure their proper observance by

sanctions proportionate to the degree of negligence or default in each case. Penal measures of this character are, in some cases, strengthened by imposing liability to a civil action for damages: since, apart from the question when insurance begins to run and whether this is determined automatically or not, any failure to comply with legal provisions must inevitably entail, if the risk insured against materialises, some damage either to the insured (if insurance is not automatic) or to the insurance institution (if benefits have already been granted before the beneficiary actually became insured), or if the contributions, which form the counterpart of the cost of the benefits granted, have not been paid.

The provisions relating to membership of insurance institutions, the system of levying contributions, and the sanctions for breaches of the law are discussed in detail in the Chapters dealing with insurance institutions and financial systems and sanctions. The nature of the administrative regulations, based on generally accepted principles regarding membership and payment of contributions, and the authorities responsible for their enforcement are described below. How an automatic system of insurance operates, to what civil liability for damages it may give rise and, lastly, the civil liabilities and loss of rights connected with a non-automatic system of insurance will be discussed subsequently.

The two final Sections deal with the features peculiar to the insurance of temporary workers, and how the principle of obligation is applied under a system of popular insurance.

§ 1. — Affiliation and the Payment of Contributions

An insurance institution, as it is called upon to grant benefits, must be in a position to verify, as soon as persons become liable to insurance, whether the obligations to which they or their employers are subject, and which constitute the counterpart to the financial burden falling on the institution, have been fulfilled.

The law must therefore prescribe rules for notifying the insurance institution concerned whenever a person subject to insurance has entered into a contract of employment (and also when the latter has terminated), must lay down how contributions shall be levied and what persons are liable for payment, and specify how any changes in the contract or conditions of employment, if they affect contribution rates, are to be notified to the insurance institution.

The duty of notifying any changes in the contract or conditions of employment is, moreover, bound up with that of paying contributions, since it is necessarily complementary thereto and

sometimes coincides with it. Payment of the contribution due is in many cases regarded as equivalent to notifying the insurance institution of the wage or risk class to which the insured belongs, since any changes in the contract of employment necessarily involve an alteration in the contribution rate, so that it is unnecessary to notify the insurance institution specially.

On the other hand, whenever the law requires that a change in the contract or in the conditions of employment shall expressly be notified, persons responsible for the payment of contributions are also responsible for complying with this formality.

It is proposed to examine the duties connected (a) with affiliation; (b) with the payment of contributions.

COMPULSION AND AFFILIATION

The duties relating to affiliation and the responsibility for fulfilling them are intimately bound up with the principles governing the grouping of insured persons; for the insured's share of responsibility in connection with affiliation will vary according to the degree of freedom enjoyed in choosing the insurance institution; while the duties of the employer will also vary in accordance with the above factors.

The main rules governing the grouping of insured persons are described in detail in Part IV, Chapter I; it will therefore suffice briefly to recall those principles connected with affiliation on which the obligations and liabilities of the insured, or their employers, depend. The various solutions adopted by different systems of grouping may be classified under four main heads, in accordance with the degree of liberty enjoyed by the insured in choosing their insurance group:

- (1) The insured are entirely at liberty to choose their insurance institution.
- (2) The insured are at liberty to choose their insurance institution from among a number of specified institutions; but if they fail to make use of this right, they become *ipso facto* insured with an institution designated by law (subsidiary compulsory affiliation).
- (3) The insured do not enjoy any liberty to choose their insurance institution, and are *ipso facto* insured with the insurance institution on which they depend (compulsory affiliation).
- (4) Lastly, the choice is left to the employer, within certain limits.

Systems of Free Affiliation

This is the system operating in Great Britain and Ireland: in both countries persons subject to insurance are at liberty to apply for membership of an approved society or not, as they please. If no application for membership is made, or is not made within the time required by law, a wage-earner is *ipso facto* regarded as a "deposit contributor", and the amounts contributed on his behalf are paid into a compulsory savings account in what is known as the "Deposit Contributors' Fund", which is administered by the Minister of Health (Approved Societies Regulations, 1924, section 7).

The cessation of employment becomes known to the insurance institution by the return of the insurance card containing the stamps by means of which the contributions are paid; and contributors are responsible for returning their cards. When a wage-earner subject to insurance leaves his employer's service, the latter is not therefore under any liability to make a declaration to that effect. Persons liable to insurance are therefore exclusively responsible for carrying out the legal formalities connected with membership.

Systems of Subsidiary Compulsory Affiliation

This system, under which persons subject to insurance are at liberty to choose their insurance institution, prevails in Austria, where the undertaking in which the insured is employed is not compulsorily affiliated to a corporate sickness fund (section 58), in Germany (general system), in Italy (new provinces), in Norway, and in Czechoslovakia. The Norwegian law, however, provides that where the insured belongs to a trade union which has established a sickness fund, membership of that fund is compulsory.

All the above laws stipulate that employers are responsible for ascertaining whether the insured have exercised their right to choose an insurance institution; and if it is impossible to ascertain whether they have actually become members of an approved substitute fund, they are required to give written notice to the insurance institution to which the undertaking is affiliated. If the insured can prove membership of a substitute fund, although already affiliated to the insurance institution on which the undertaking is legally dependent, the employer must in that case instruct the fund to strike the insured off its list of members, since he is already insured elsewhere. These rules, expressly laid down by

the German Social Insurance Code (section 519) and the Norwegian Act (section 9) are implicitly contained in the Austrian and Italian Acts.

The responsibility for making the declaration rests in all cases on the employer, though the insured are at liberty to select their own insurance institution within the limits defined by law, and, in that event, enjoy the right to make the required declaration first. The Czechoslovak Act, however, goes further; and, under section 17, the obligation to make the declaration rests on the employer, even where the insured has made use of his right to join a substitute fund. When the insured leaves his employer's service, or a change in the nature of the contract of employment putting an end to the liability to insurance occurs, the employer may be required in all systems of subsidiary compulsory affiliation to notify the competent insurance institution of the fact; but whereas employers are always responsible for making the required declaration when the insured have failed to exercise their right to choose the insurance institution, the position is different when the right has been exercised.

Both in Austria and Germany, joining a fund selected by the insured frees the employer from any duty to take a declaration if the insured leaves his service (section 317 of the German Insurance Code and section 60 of the Austrian Act). Conversely, section 9 (5) of the Norwegian Act of 6 August 1915 provides that: "the employer shall notify the proper sickness fund when an employed person leaves his service, or if the liability to insurance ceases for some other reason", and section 25 of the Italian Legislative Decree of 29 November 1925: "the employer shall notify the competent fund when the insured leaves his service". The general terms used in both these laws to define the insurance institutions which must be notified when the insured is no longer in an employment involving liability to insurance include all insurance institutions from among which the insured is at liberty to choose; one may therefore conclude that the duty of notifying that the insured has left his employer's service subsists, even when he has failed to exercise his right to choose an insurance institution. Lastly, section 17 of the Czechoslovak Act explicitly, and in every case, places the duty of notifying the insured's departure from service on the employer, whether the former has exercised his right to choose the insurance institution or not: "the employer shall be bound to notify the competent sickness insurance institution (district, agricultural, works, guild, or corporate sickness fund) of a person liable to insurance employed by him leaving his work or service".

Systems of Compulsory Affiliation and System under which the Employer Chooses the Insurance Institution

Compulsory membership of a specified institution prevails in Germany (miners' insurance), in Austria where the undertaking in which the insured is employed is compulsorily affiliated to a guild sickness fund, in Belgium (seamen's insurance), in Esthonia, in France (Alsace-Lorraine, seamen's and miners' insurance), in Japan, Latvia, Lithuania, Luxemburg, Poland, Roumania, and the Serb-Croat-Slovene Kingdom. In the last-mentioned country, however, commercial employees are at liberty to join one of the two mutual benefit societies established at Ljubljana and Zagreb.

In France (Alsace-Lorraine) members of approved auxiliary funds are affiliated to the district or occupational fund with which the undertaking is connected; but their rights in that case are suspended, and they are not entitled to vote or to act as officers in the funds of which they are for the time being members.

In Hungary, employers are empowered to insure all the persons employed by them as commercial employees, either with one of the two mutual benefit societies at Budapest or Debreczen or with the competent district fund.

In all countries where the law provides for compulsory membership of a specified fund or the designation of the fund by the employer, the latter is always responsible for notifying the insurance institution concerned of the engagement or discharge of the persons liable to insurance

COMPULSION AND THE PAYMENT OF CONTRIBUTIONS

All compulsory insurance laws impose on employers the duty of paying contributions, while authorising them to recover that part of the contribution for which the insured are liable by deduction at source (i.e. from wages). This plan is a general one, and most systems which grant the insured liberty to choose their insurance institution also impose on employers the duty of paying contributions on behalf of the insured, irrespective of the insurance institution chosen: this is the case, for instance, in Czechoslovakia, Great Britain, Italy, and Norway.

The only exceptions to this general rule are found in Austria and Germany, in those cases where the insured have joined a substitute fund of their own free will. An employer is in that case required to pay the insured, together with wages, the employer's share of the contribution calculated as if they had not joined a substitute

fund. Further, the Insurance Office may, in Germany, if an employer is in arrears with his contributions, decide that the latter shall only pay that part of the contribution for which he is liable, and that compulsorily insured persons shall pay their own share.

The rules relating to the payment of contributions are closely connected with the obligation to notify the insurance institution of any circumstances involving a change in the contribution rate. This does not, however, necessarily involve giving written notice, and several insurance laws simply provide that employers are required to keep proper documentary evidence to enable the supervisory authorities to check whether the contributions paid on behalf of insured persons really correspond to their wages and the nature of their employment. The duty of formally notifying the insurance institution concerned of any circumstances affecting the contribution rate payable is specified by law in Bulgaria, Czechoslovakia, France (Alsace-Lorraine), Germany, Japan, Luxemburg, Norway, Poland, and the Serb-Croat-Slovene Kingdom. There is an exception to this rule in Germany when the insured has voluntarily joined a substitute fund, and his contributions are not deducted at the source.

§ 2. — Automatic Systems of Insurance and the Civil Liability of Employers as regards Insurance Institutions

Austria, Belgium (seamen's insurance), Czechoslovakia, Esthonia, France (Alsace-Lorraine; seamen's insurance); Hungary, Latvia, Lithuania, Luxemburg, Norway, Poland, Russia, Serb-Croat-Slovene Kingdom.

If liability to insurance and the date of entry into insurance coincide, this is equivalent to saying, in other words, that a wage-earner is *ipso facto* insured as soon as he becomes liable to insurance. Insurance therefore commences as soon as a person becomes liable and not on the date of joining an insurance institution; and any qualifying period of insurance begins to run from the same moment. When that period has elapsed, the risk is automatically covered, even if there has been failure to comply with legal requirements; and it is only necessary to prove that the person is in fact liable to insurance to set the machinery of insurance into motion. Similarly, the fact that a wage-earner is still employed in a capacity rendering him liable to insurance is in itself sufficient to secure the risk remaining covered; and failure to pay contributions, through

non-compliance with legal requirements, does not affect the position in this respect. Once the conditions connected with the qualifying period have been complied with, right to benefit only depends on the conditions of the contract of employment, which constitutes the basis of the obligation to insure. On the other hand, if the insured ceases to be actually employed owing to sickness, this circumstance is never in itself sufficient to put an end to insurance. The insured's rights are therefore acquired and maintained independently of the performance of the obligations imposed by law as regards affiliation and payment of contributions.

In Germany persons subject to compulsory insurance become *ipso facto* members of a sickness fund as soon as they enter into an employment involving the obligation to insure (section 306 of the Social Insurance Code). Liability to insurance ceases as soon as the contract of employment, constituting the basis of this obligation, terminates or is altered in a way which involves the disappearance of one of the conditions on which the obligation to insure is based. Failure to pay contributions in contravention of the law does not affect the status of the insured so long as the latter remains a wage-earner within the meaning of the Act. And when the insured is unemployed, or the contract of employment terminates as a result of sickness, the insured's rights remain unaffected during the continuance of unemployment or sickness (sections 214 and 311).

Similar provisions exist in all automatic legal systems of insurance. They only differ as regards the conditions with which the insured must comply to retain his insured status during the period of unemployment or sickness.

If insurance is thus automatic, and only depends on carrying out the provisions of the contract of employment, and the employer is responsible for the execution of the formalities connected with the acquisition or maintenance of insured status, no failure to do so on his part can in any way prejudice the insured's rights.

These subsist unaltered whether the employer has performed his legal obligations or not; conversely, however, the insurance institution can call the employer to account, either for a breach of the law as to declarations and payment of contributions entailing liability to a fine or other penalties, or when, apart from any penal sanction, the employer's negligence involves a civil liability for damages. A civil action of this kind would result in the employer being made liable for the payment of any benefits granted to the insured if the latter had fallen ill before the requisite formalities had

been complied with, or the contributions due had been paid; this therefore constitutes a sanction proportionate not to the degree of negligence, but merely to its consequences.

Whereas all laws provide for penal sanctions, intended to strengthen the obligations imposed on employers and wage-earners, the cases where an insurance institution can bring a civil action for damages against the employer are relatively few.

The Austrian Act provides that an employer who fails to make the required declaration in respect of the liability of a wage-earner to insurance shall be liable, without prejudice to any penal sanctions, for refunding the entire expenses incurred by the fund for benefits granted to a person in respect of whom a declaration had not been made at all or within the period prescribed in accordance with the law or its own rules.

Similar provisions are contained in section 12 of the Hungarian Act; section 24 of the Italian Decree of 4 March 1926; section 9, (4) and (6), of the Norwegian Act; section 20 of the Czechoslovak Act; and section 11 of the Serb-Croat-Slovene Act.

§ 3. — Loss of Rights, and Civil Liabilities under Systems where Insurance is not Automatic

Great Britain, Northern Ireland, and Irish Free State; Bulgaria · Japan; Roumania.

When entry into insurance does not automatically coincide with the date when the contract of employment begins, or when title to benefit does not depend entirely on the existence of such a contract, the acquisition of insured status, or the right to full benefit, depends upon effective application for membership of the competent insurance institution, and payment of the contributions on which the maintenance of insured status is dependent. Omission to make the requisite declaration, or failure to pay contributions, therefore entails the loss of the insured's rights, including the right to benefit. Generally, however, the automatic character usually associated with compulsory systems of insurance continues to prevail under the law in some degree, irrespective of any loss of rights which may have occurred

Thus in certain systems both the right to benefits in kind and the qualifying period connected with these benefits begin not on the same date as affiliation itself, but on the date when liability to

insurance commences, or, in other words, when the contract of employment comes into force. The right to money benefits, on the contrary, is more intimately connected with the execution of certain legal formalities relating to affiliation and payment of contributions. This is the case for instance in Great Britain, Northern Ireland, and the Irish Free State.

In Japan, on the contrary, insurance coincides absolutely with the date of actual affiliation; but neither the Act itself nor the administrative regulations issued in pursuance of it provide for any loss of rights for non-payment of contributions, at all events during the currency of the contract of employment on which the obligation to insure is based.

Lastly, in Roumania, the right to benefit depends on membership of a corporation, and any interruption in the payment of contributions involves loss of existing rights, either immediately in the case of money benefits, or after four weeks as regards benefits in kind.

Although the loss of rights referred to above is always due to comply with legal requirements as to membership or payment of contributions, the consequences of breaches of the law of a similar nature, in either of these respects, differ considerably under different laws. Moreover the loss of rights may be, and generally is, limited to one part of the rights conferred by insurance; and the features common to the various systems in this respect are not sufficiently clearly defined to enable a satisfactory classification, based either on cause or effect, to be made.

The loss of rights where insurance is not automatic may mean depriving the insured of their rights whenever an employer responsible for the execution of the legal formalities connected with the acquisition and maintenance of insured status fails to carry out his obligations in this respect. With a view, therefore, to securing wage-earners against default or negligence on the part of employers, certain legal systems where insurance is not automatic render the latter liable for any damage caused to the insured owing to failure to declare or to pay contributions. These provisions, where they exist, secure that the risk insured against remains covered throughout the period during which the obligation subsists. But a guarantee of this kind is obviously less perfect than that derived from an automatic system of insurance; since the burden of proving the alleged failure or negligence on the employer's part to carry out his obligations rests on the claimant, in other words, on the wage-earner. The latter has also to meet the cost of sickness and any legal costs to which he may be put, until judgment has

been given in his favour. Further the employer's liability is only of advantage to the insured in as far as the employer is solvent: a right of action against the employer, therefore, while undoubtedly constituting a valuable guarantee in favour of the insured, is neither equivalent to, nor as certain in its effects as, automatic insurance.

Moreover, only a small number of the systems where insurance is not automatic actually confer this right on the insured; and the laws in Great Britain, Northern Ireland, and the Irish Free State are the sole instances where the employer's liability to an insured, whose rights have been prejudiced by his failure to carry out the obligations devolving on him, is systematically organised.

The main features of systems where insurance is not automatic therefore include:

- (1) The conditions prescribed for obtaining membership and maintaining insured status.
- (2) The consequences of failure to affiliate or pay contributions.
- (3) The rights which the insured may be able to enforce against an employer.

It is proposed to discuss the various solutions adopted when insurance is not automatic, and also to describe the rules applicable to the acquisition and maintenance of insured status, the consequences of failure to comply with legal requirements, and the rights of the insured to compensation for any damage sustained.

The rules connected with the acquisition and the maintenance of insured status will be supplemented by a brief review of the chief conditions concerning the manner in which the risk is covered, as they affect either the partially automatic character of insurance or the possible loss of the insured's rights. But it will be unnecessary to discuss the provisions connected with the minimum length of the period of sickness which must elapse before the insured is entitled to benefits (waiting period) since these merely aim at securing that risks of negligible economic importance, likely moreover to recur with undue frequency, shall not be covered by insurance. They could, moreover, only affect persons who are actually insured, whether automatically or otherwise, who have complied with the conditions required to entitle them to benefits in the event of the risk materialising, and who are not, therefore, liable to any loss of their rights owing to non-declaration or non-payment of contributions.

GREAT BRITAIN

ENTRY INTO AND MAINTENANCE IN INSURANCE: ACQUISITION OF TITLE TO BENEFIT

The system of insurance established by the British Act results in insurance being automatic, in as far as it is intended to guarantee medical treatment. All persons of the age of 16 and upwards employed within the meaning of the Act are in that capacity subject to insurance (section 1 (1)).

On the other hand, insured persons do not become entitled to any cash benefit until 26 weeks have elapsed since their entry into insurance, and 26 weekly contributions have been paid by or in respect of them, or to full cash benefits until 104 weeks have elapsed since their entry into insurance and 104 weekly contributions have been paid. The qualifying period therefore commences with the first contribution paid, and failure to pay the minimum number of contributions specified by the Act prevents benefits being granted (section 13 (3)).

Lastly, insured persons who not having joined an approved society become "deposit contributors" and, as such, are affiliated to the Deposit Contributors' Fund, are not entitled to benefit unless the sums required for the payment of any sickness, disablement or maternity benefit payable can be paid out of the money standing to their credit in the Fund (section 54 (1) (b).)

In view of the fact that both sickness and invalidity risks are covered under the same system of insurance, loss of insured status in Great Britain entails very serious consequences, since it causes the insured to lose all their existing rights, and in case of subsequent entry into insurance, the insured person is required to complete the whole of the prescribed qualifying periods, i.e. 26 weeks for the minimum sick benefits and 104 weeks for invalidity benefits, before he is entitled to benefit. For this reason the conditions stipulated by the British Act for the maintenance of insured status, even though contributions have not been paid, are particularly comprehensive. Insurance does not cease either when the risk insured against materialises or while the insured is unemployed by reason of sickness. The patient continues to be regarded as insured so long as his condition justifies the grant of the benefits to which he is entitled under the Act, even though the contract of employment has terminated as a result of sickness. Similarly, the beneficiary of an invalidity pension continues to be entitled to the benefits in kind guaranteed by the Act. Lastly, in calculating the twelve months during which the insured is maintained in insurance although he has ceased to be a wage-earner, no account is taken of any period of sickness or invalidity (section 3 (3)).

An insured person may, however, lose his insured status or his right to full benefits as a result of:

- (1) attaining the age of 70 (65 after 2 January 1928),
- (2) obtaining a certificate of exemption from the obligation to insure, although a wage-earner within the meaning of the Act;
- (3) ceasing to be a wage-earner within the meaning of the Act;
- (4) falling into arrears with his contributions.

When insurance ceases owing to the contributor reaching the age limit, the loss of right to sickness and invalidity benefits is immediate. But title to medical benefit normally continues for life.

If a certificate of exemption is issued to an insured person by the Central Department concerned, there is likewise immediate loss of right to money benefits, but right to medical benefits continues (*Approved Societies' Handbook*, 1927, par. 254).

When a member ceases to be employed within the meaning of the Act, he remains a member for one year after the end of the week in which employment ceases, after which right to benefits terminates, and in calculating this period of a year no account is taken of any notified periods of proved sickness or invalidity. He remains, however, entitled to medical benefit until 30 June or 31 December first occurring after the expiry of a period of eighteen months from the date on which he ceases to be employed within the meaning of the Act, the first twelve months of this period being extensible by sickness or invalidity (*Approved Societies' Handbook*, par. 243).

The benefits to which a member is entitled in any calendar year are subject to reduction or suspension if the deficiency in his contributions for the preceding "contribution year" exceeds the margin allowed and, in the case of a voluntary contributor, failure to pay a certain minimum number of contributions entails loss of insured status. Weeks of sickness are excused in reckoning the deficiency.

THE CONSEQUENCES OF FAILURE TO BECOME A MEMBER OF AN APPROVED SOCIETY

When a person employed within the meaning of the Act has not become a member of an approved society by 1 October or 1 April next after the half-year during which he became liable to insurance, either through failure to apply for membership, or because his application has been rejected, he is automatically registered with the Deposit Contributors' Fund, where an account is opened in his name to which all the sums contributed on his behalf are credited.

This involves a complete change in the nature and consequences of the obligation to insure: whereas members of approved societies are effectively insured, so that the good and bad risks compensate one another and the funds shared in common enable benefits to be granted proportionate, not to the contribution, but to the degree and duration of the loss involved, the amounts standing to the credit of deposit contributors are paid into a subsidised individual savings account out of which the cost of all the benefits they need must be defrayed. The right to benefit expires when the contributor's account ceases to show a credit balance; and a sufficient credit balance must be accumulated before the contributor becomes entitled to fresh benefits.

A sum is prescribed annually in respect of each deposit contributor for the purpose of meeting the cost of the medical benefits granted; and a deposit contributor's right to medical treatment is dependent on the amount standing to his credit in the fund being sufficient to provide the proper proportion of the cost of medical benefit and administration (section 54, of the Act and par. 13 (2) of the Deposit Contributors' Regulations, 1924).

Nevertheless, a deposit contributor, by or in respect of whom any contributions have been paid during a half-year, is entitled to medical benefit during an initial period of twelve months, independent of the amount standing to his credit in the fund or the number of contributions paid on his behalf. When, however, the amount standing to the credit of a deposit contributor is insufficient to provide for the appropriate deduction in respect of the cost of medical benefit and administration a deposit contributor is regarded in debt for the amounts which have been advanced on his behalf, and these may be deducted from the amount accruing to his credit in the fund. If at the end of the half-year next but one commencing after the date on which such deduction would ordinarily have been made there is still not sufficient to his credit to provide for the deduction, the deposit contributor is suspended from medical benefit until the amount credited in the fund is sufficient to meet the deficiency in respect of the cost of medical benefit and administration during the previous periods and the cost during the coming half-year (Deposit Contributors' Regulations, 1924, par. 13 (4) and (5)).

Deposit contributors are only entitled to cash benefits in so far as the amounts standing to their credit, after deduction of the proper proportion for the cost of medical benefit and administration, are sufficient for that purpose.

Failure or omission to join an approved society therefore results in the guarantees provided by a compulsory system of insurance being transformed into a simple obligation to constitute a subsidised savings account. The results of this transformation of the manner in which the risk is covered are particularly grave in the case of persons subject to serious risks, whose applications for membership of an approved society are precisely the most liable to rejection. It is true that these persons are entitled to medical benefit during an initial period of twelve months regardless of the number of contributions paid; but as soon as this period has expired, they are only

entitled to the medical benefits of insurance so long as their account shows a credit balance at the conclusion of the preceding six-monthly period. Further, they will only be entitled to cash benefits to the extent of the credit balance standing to their account.

CONSEQUENCES OF OMISSION OR FAILURE TO PAY CONTRIBUTIONS

Omission or failure to pay contributions may prevent the completion of the prescribed qualifying period, before the end of which a contributor is not entitled to cash benefits, and may in any event involve loss or reduction of benefits owing to arrears. It may be noticed, however, that omission or failure to pay contributions cannot extend beyond a certain period, and, in any case, for more than six months, without the contributor's knowledge. For the latter can retain in his possession the insurance card on which the number of contributions paid is indicated by the stamps affixed, and the employer is only entitled to keep it for the time required to affix the insurance stamps (*Collection of Contributions Regulations, 1924*, par. 7). Further, when the contributor fails to exercise his right in this respect and allows the employer to retain his card, the latter is required to deliver the card to the contributor on demand, or at the termination of the six-monthly period of validity, or when the contributor leaves his service.

It would therefore appear that more serious consequences are likely to arise from legal registration with the Deposit Contributors' Fund, as a result of omission or failure to join an approved society, than from any failure or negligence to pay contributions, which cannot continue to occur for more than six months without the contributor's knowledge.

CLAIMS FOR DAMAGES AGAINST EMPLOYERS

An employer may be rendered liable for the retrospective payment of contributions he has failed to pay, and also in connection with any benefits of which the insured has been deprived as a result of the employer's negligence.

Legal Action for the Payment of Contributions

If an employer fails to pay any contributions for which he is liable, he is liable for each offence, on summary conviction, to a fine not exceeding £10, and also a sum equal to the amount of the contributions which he has so failed or neglected to pay during the two years preceding the date of the offence of which he is convicted (sections 96 and 97 as amended).

Proceedings against an employer under the Act for the offence of failing to pay any contribution in respect of a person may be brought at any time within one year from the date of the commission of the alleged offence, or within three months from the date on which evidence sufficient, in the opinion of the Minister, to justify a prosecution for the offence comes to his knowledge, whichever is the later (section 97 (a) and (b)).

Since contributions paid as a result of such action do not confer a retrospective right to benefit in respect of the period during which the insurable risk was not covered as a result of the employer's negligence, special provisions have been inserted in the Act enabling a contributor to bring an action for the payment of the value of the lost benefits.

Legal Action for the Payment of Benefits

Where an employer has failed to pay any contribution which he is liable to pay in respect of any insured person in his employment, or has failed to comply, in relation to any employee, with the requirements of any regulations relating to the payments and collection of contributions, and by reason thereof the employee or any person claiming through him has lost in whole or in part any benefits to which he would have been entitled under the Act, the employee or person so claiming is entitled to recover summarily from the employer as a civil debt a sum equal to the amount of any benefit which he has lost as aforesaid (section 98 (1)).

Proceedings under this section may be brought at any time within one year after the date on which the employee, but for the failure or neglect of the employer, would have been entitled to receive the benefit which he lost (section 98 (5)).

IRISH FREE STATE AND NORTHERN IRELAND

The provisions of the laws regulating insurance in these countries are similar to those in the British Act.

BULGARIA

ENTRY INTO AND MAINTENANCE IN INSURANCE: ACQUISITION OF TITLE TO BENEFIT

The administrative regulations dated 25 June 1924 issued in pursuance of the Act provide that persons subject to insurance are to be regarded as insured from the day on which they are in possession of an insurance book (par. 33 of the regulations).

Payment of contributions by insurance stamps affixed to the book must be proved before insurance begins to operate, in other words, before the benefits prescribed in the Act can be granted (par. 90 of the regulations).

An insured person who has paid his contribution for eight consecutive weeks is entitled to the prescribed benefits (section 18).

Membership of the fund continues in cases of proved unemployment lasting not more than eight weeks (section 18).

Both employer and insured cease to be liable for contributions during the currency of an illness involving cessation of work.

There is no obligation to notify the cessation of employment within the meaning of the Act which involves cessation of insurance.

As an insured person can only obtain benefits on presentation of his insurance book in which the payment of contributions is recorded, the presentation of the book enables the loss of insured status to be noted.

CONSEQUENCES OF FAILURE TO AFFILIATE OR PAY CONTRIBUTIONS

The rules governing entry into insurance and maintenance of insured status, together with the right to benefits, render the performance of the formalities prescribed by law with reference to affiliation and payment of contributions an indispensable preliminary to the operation of insurance, and failure to affiliate or pay contributions renders it impossible to acquire or maintain insured status.

THE CIVIL LIABILITY OF THE EMPLOYER TOWARDS THE INSURED AND ITS ENFORCEMENT

Section 2 of the Act provides that employers shall be responsible for the insurance of wage-earning and salaried employees; but there are no provisions either in the Act itself, or in the administrative regulations issued under it, defining the circumstances under which this liability can be enforced in favour of insured persons who may have been deprived of their right to benefits owing to the failure of the employer to comply with legal requirements.

JAPAN

ENTRY INTO AND MAINTENANCE IN INSURANCE: ACQUISITION OF TITLE TO BENEFIT

Every insured person is deemed to be insured from the day on which he is employed in the undertaking (section 17 of the Act), but an insured can only obtain the benefits to which he is entitled on presentation of a card proving that the declaration of liability to insurance has been made, and that the holder is in fact an insured person.

The only causes which put an end to insurance specified in the Act are the death of the person insured, or the fact that he has ceased to be employed in an undertaking subject to insurance, or that he has become employed as an administrative employee at an annual remuneration exceeding 1,200 yen a year (section 13).

Right to benefits may continue in the event of sickness, although the patient has ceased to be insured, provided that the sickness in respect of which benefits are granted occurred during the period of insurance.

CONSEQUENCES OF FAILURE TO AFFILIATE OR PAY CONTRIBUTIONS

Entry into insurance depends on the presentation of a declaration of liability to insurance, and on the contributor having actually become a member of the competent insurance institution. Although insurance is not automatic, medical benefits are granted in urgent cases even if the insured fails to present the card proving his insured status. Neither the provisions of the Act nor the administrative regulations issued under it make the preliminary payment of contributions a condition to the operation of insurance.

THE CIVIL LIABILITY OF THE EMPLOYER TOWARDS THE INSURED AND ITS ENFORCEMENT

Japanese law does not provide for any method by which wage-earners whose rights have been prejudiced by the employer's negligence can enforce claims for damages against the latter.

ROUMANIA (Former Kingdom and Bessarabia)

ENTRY INTO AND MAINTENANCE IN INSURANCE. ACQUISITION OF TITLE TO BENEFIT

Insured status is reserved to members of occupational or trade associations established under the Act of 1912, and membership of these bodies is dependent on an application for membership. When an insured person has been admitted, his membership continues as long as he is employed as a foreman, artisan, journeyman, apprentice, unskilled worker, or day labourer.

Membership of an association entitles him to benefits in kind. The right continues for four weeks if an insured person interrupts the payment of his contributions (sections 117 and 118).

Right to benefits in cash is dependent on the payment of contributions for six weeks in the case of sickness benefit and for 52 weeks in the case of funeral benefits (section 116).

CONSEQUENCES OF FAILURE TO AFFILIATE OR PAY CONTRIBUTIONS

The maintenance of insured status depends, as in the Bulgarian law, on compliance with legal requirements, and any breaches of the law render it either impossible to acquire a right to benefits or involve the loss of insured status.

THE CIVIL LIABILITY OF THE EMPLOYER TOWARDS THE INSURED AND ITS ENFORCEMENT

Roumanian legislation does not provide any method of enforcing any rights of the insured which may have been prejudiced by the employer's negligence.

§ 4. — Special Features of Systems for Insuring Temporary or Casual Workers

Most laws extending the obligation to insure to temporary or casual workers provide a special regime applicable to the latter, which the insured are themselves responsible for applying, both as regards membership and the payment of contributions; and failure to comply with legal requirements in both these respects prevents a wage-earner becoming insured.

The special features of systems applicable to temporary workers only are due to the difficulty for an employer either to fulfil his duty to notify the insurance group of the engagement and departure of workers of this kind, who vary from day to day, or to check the correctness and validity of previous declarations affecting them. They can also be justified by the possible complications connected with the payment of contributions in respect of periods of employment not exceeding a few days, or in some cases even a few hours; while, lastly, the exceptions to the rule that insurance automatically applies to temporary workers may be justified by the difficulty and uncertainty of subsequently ascertaining and checking to what occupational category, involving liability to insurance, a wage-earner of this class actually belongs. The difficulties of applying to temporary workers the general provisions intended to apply to regular workers under the various laws do not constitute an insurmountable obstacle to enforcement; nevertheless, the Yugoslav and Czechoslovak insurance systems are the only ones under which temporary workers are covered by all the provisions applicable to regular wage-earners. In Austria employers of temporary workers are responsible for the regular payment of contributions, and are liable for any failure or negligence in this respect.

The main provisions of the various laws relating to the insurance of temporary workers are discussed and analysed below.

DECLARATION OF LIABILITY TO INSURANCE AND PAYMENT OF CONTRIBUTIONS

Obligation on the part of persons temporarily employed to register with an insurance institution is laid down in the following laws: German Social Insurance Code (section 444); sections 23 and 24 of the Austrian Act of 29 October 1921, section 444 of the German Social Insurance Code, as applicable in France to Alsace-Lorraine; Latvian Order of 29 September 1924; section 17 of the Polish Act. There are exceptions to this rule in Czechoslovakia and in the Serb-Croat-Slovene Kingdom, where responsibility for making a declaration in respect to temporary workers devolves on the employer: this rule is explicitly contained in section 10 of the Serb-Croat-Slovene Act, and implicitly in the Czechoslovak Act. In the latter case, the administrative regulations provided for in section 248 have not yet been issued.

Temporary workers are liable for the payment of contributions in Germany and in France (Alsace-Lorraine) under section 450 of the Social Insurance Code; and also in Poland, under section 52 (5) of the Act.

The obligation for temporary workers to pay contributions in Germany and France (Alsace-Lorraine) only applies to that fraction of the contribution for which the wage-earner is legally responsible, and the Federation of Communes is liable for the payment of the contributions which represent the employers' share (section 454 of the German Social Insurance Code).

In Austria the employer is liable for the contribution, but it is the duty of the insured to make the actual payment (section 27 (2) of the Act of 21 October 1921); and the latter receives in return a document which constitutes a receipt for the contributions paid, and also indicates any period during which he may be unemployed. Employers are entitled to refer to these

documents to verify whether contributions have actually been paid; and where this is not the case, they may pay the contributions due themselves, and make a deduction from the insured's wages corresponding to that part of the contribution for which he is liable (section 30 of the Act of 21 October 1921). If a temporary worker is in arrears with his contributions, and is unable to pay them, the employers by whom he has been employed during the four weeks immediately preceding the date of his default are jointly and severally liable for the aggregate amount due as contributions (section 31 of the Act of 21 October 1921).

In Latvia, contributions are paid by the employer, who affixes a stamp for this purpose to the insurance card belonging to a wage-earner temporarily in his employ (section 26 of the Order of 8 September 1923).

Both in Czechoslovakia and in the Serb-Croat-Slovene Kingdom temporary workers are insured in the same manner as regular wage-earners, and the employer is responsible for paying the contributions due (sections 162 of the Czechoslovak Act and 10 of the Serb-Croat-Slovene Act). The law in the former country provides that where two or more persons in agreement employ the same worker even for separate wages, they shall be jointly and severally liable for his insurance contribution based on his total wages. If a worker is employed by two or more employers for separate wages in any other case, he shall be liable to insurance only on account of his principal employment (section 169 of the Act).

ACQUISITION AND LOSS OF INSURED STATUS

Sections 443 and 444 of the German Social Insurance Code provide that casual workers become liable to insurance by being entered on a special register.

Section 446 provides that a registered person shall remain a member even during periods when he is temporarily out of employment for remuneration.

The acquisition and maintenance of insured status by casual workers are subject to similar provisions in Austria (section 23 of the Act of 21 October 1921); in France (Alsace-Lorraine), in Latvia (Order of 8 September 1923); and in Poland (section 10 of the Act of 1920).

In Czechoslovakia and in the Serb-Croat-Slovene Kingdom the general provisions applicable to regular workers also apply to casual workers. The only exceptions provided in the latter case apply to persons irregularly employed as domestic servants, whose insurance is to be governed by special regulations. The special instructions provided for in section 248 of the Czechoslovak Act, applicable to persons employed in an exceptional manner, have not yet been promulgated. In both these countries, therefore, temporary or casual workers are automatically insured on the same conditions as regular wage-earners.

§ 5. — Special Features of Popular Systems of Insurance

The various systems of compulsory popular insurance contain either uniform rules regarding membership and the payment of contributions applying to all the persons liable to insurance, whether the latter are wage-earners or not (the employer in that case having no share or responsibility as regards the acquisition or maintenance of insured status), or make a distinction between different classes of persons subject to insurance on the ground that they are or are not wage-earners.

In the latter case, the obligations connected with membership and the payment of contributions are determined by the same rules as those which prevail under wage-earners' insurance systems; in which case independent workers are responsible, in view of their status, for carrying out the requisite formalities for acquiring and retaining their rights as insured persons.

The Chilean Act is the only one which provides for transferring the responsibility for making the declaration that the subject is liable to insurance to the employer. The duty of paying contributions, subject to a right of deduction from the insured's wages, is, however, more frequent, and is found in Chile, in the three Swiss Cantons of Appenzell (Outer Rhodes), St. Gall, and Thurgau, and also, in certain cases, in Portugal.

Nevertheless, no popular system of insurance, in spite of its similarities as regards dependent workers with systems of wage-earners' insurance, recognises the principle of automatic insurance. The rules relating to membership and payment of contributions prevailing in Basle Town and Thurgau are, however, practically equivalent to partially automatic insurance. It is proposed to describe the legal provisions of popular systems of insurance connected: (a) with the formalities relating to membership and the payment of contributions; (b) the conditions requisite for the acquisition and maintenance of insured status.

DECLARATION OF LIABILITY TO INSURANCE

In any system of popular insurance the duties and responsibilities connected with the insurance of wage-earners must be clearly distinguished from those connected with the insurance of independent workers.

In *Chile*, employers are responsible by law for making a declaration regarding workers employed by them liable to insurance and for the payment of contributions on their behalf, which is proved by affixing a receipt stamp to the worker's wage book.

Independent workers are personally responsible for entering their name on the register of insured.

In *Portugal* persons liable to insurance are responsible for making the necessary declaration, they are at liberty to choose between assuming responsibility for the payment of contributions personally and having the contribution deducted from their wages (section 13). In the latter case the employer is liable for the regular payment of all contributions due (sections 13 and 68).

Paying orders issued by insurance institutions for recovering overdue contributions which have not been paid by the insured are always collected by deduction from wages. An employer is liable for any omission or failure to pay the amounts so claimed (section 68).

In *Switzerland* the insured are always responsible for making the necessary declaration (Appenzell (Inner Rhodes), section 15 of the Order of the Grand Council of 29 November 1920; Appenzell (Outer Rhodes), section 7 of the Act of 30 April 1916, Basle Town, section 2 of the Act of 19 November 1914, amended by the Acts of 10 October 1918 and 23 February 1922, St. Gall, section 21 of the Act of 28 May 1914, amended by the Act of 28 November 1919, Thurgau, section 30 of the Act of 24 April 1926).

The principle of subsidiary affiliation has moreover been established by law in Basle Town and Thurgau; and any person who is unable to prove, at the expiration of the period during which he is entitled to choose a fund, that he is actually a member of an institution authorised to carry on compulsory insurance is *ipso facto* registered as a member of the Public Fund by administrative decision (Basle Town, section 2; Thurgau, section 14).

In three Cantons, Appenzell (Outer Rhodes), St. Gall, and Thurgau, the authority granted by section 2 (c) of the Federal Act to adopt deduction at source (i.e. from the wages of the insured) as a method of paying contributions has been made use of (Appenzell (Outer Rhodes), section 9; St. Gall, section 59; Thurgau, section 14).

The law as applied in Appenzell (Outer Rhodes) places the responsibility for deciding whether the employer shall be responsible for the payment of contributions on the commune (section 2 (3)).

Failure to pay contributions is not a cause of exclusion from insurance in Basle Town and Thurgau; and the law in the former case makes the Canton liable to the insurance institutions, which are entitled to claim the refund of contributions that have not been paid by compulsorily insured persons, provided they transfer their right of action against the insured to the Canton (section 19). In Thurgau the communes are responsible by law for the payment of contributions which have not been paid by compulsorily insured persons; but they are entitled to recover from the insured (section 16).

ENTRY INTO AND MAINTENANCE IN STATUS

In all systems of popular insurance, entry into insurance is dependent on the insured actually becoming a member of an institution authorised to undertake compulsory insurance, and the date from which any qualifying periods specified commence depends on actual membership and the regular payment of contributions; fulfilment of these legal obligations therefore constitutes a condition precedent to entry into insurance and the maintenance of insured status.

No system of popular insurance is therefore completely and absolutely automatic; but the system of subsidiary legal affiliation, and the fact that the insured retain their insured status, even though unable to pay their contributions, as is the case in Basle Town and Thurgau, are practically equivalent to automatic insurance. Where the insured has failed to exercise his right to choose within the time prescribed by law the insurance institution to which he wishes to belong, he becomes *ipso facto* a member of a public insurance fund by administrative decision. On the other hand, failure to pay contributions cannot in either of these Cantons involve loss of insured status so long as the conditions which involve liability to insurance subsist; and in this case the cantonal or communal authorities are substituted for the defaulting contributor.

In both these Cantons, persons liable to compulsory insurance therefore remain covered against sickness risks (subject to the fulfilment of the conditions relating to the qualifying period) from the date of voluntary affiliation, or from the date on which they are registered with a public insurance fund by administrative decision.

TABLE I — BRANCHES OF ECONOMIC ACTIVITY

Country 1	Industry 2	Commerce 3	Agriculture 4	Navigation 5	Railways 6
AUSTRIA . .	Covered	Covered	Covered in 8 of the 9 pro- vinces	Covered	Covered
BELGIUM .	—	—	—	Covered	—
BULGARIA .	Covered	Covered	Covered	Covered	Covered
CHILE .	Covered	Covered	Covered	Covered	Insured for medical aid only
CZECHO- SLOVAKIA	Covered	Covered	Covered	Covered	Covered
ESTHONIA . . .	Undertakings employing at least 5 workers are covered	—	—	Inland navi- gation only is covered.	—
FRANCE: (Except Alsace- Lorraine)	Miners only are covered	—	—	Ocean navi- gation only is covered	Covered
Alsace-Lorraine	Covered	Covered	Covered	Inland navi- gation only is covered	Covered
GERMANY . .	Covered	Covered	Covered	Covered	Manual work- ers only are covered.
GREAT BRITAIN AND NORTHERN IRELAND; IRISH FREE STATE	Covered	Covered	Covered	Covered	Manual work- ers are covered.
GREECE .	Covered	Covered	—	Covered	Covered
HUNGARY . .	Covered	Covered	—	Covered	Covered
ITALY (New Provinces)	Undertakings using machines or employing at least 20 workers are covered.	—	—	Inland navi- gation only is covered.	Covered
JAPAN .	Dangerous fac- tories or those employing at least 10 workers and all mines are covered	—	—	—	—
LATVIA . .	Covered	Covered	—	Vessels mak- ing distant voyages are excluded	Covered
LITHUANIA	Covered	Covered	—	—	Covered
LUXEMBURG .	Covered	Covered	—	—	—
NORWAY . .	Covered	Covered	Covered	Vessels mak- ing voyages abroad of more than 10 days are excluded.	Covered
POLAND . .	Covered	Covered	Covered	Covered	Covered
PORTUGAL . .	Covered	Covered	Covered	Covered	Covered
ROUMANIA: Former Kingdom and Bessarabia	Covered	—	—	—	—
Ardeal . . .	Covered	Covered	Covered	—	—
Bukovina . .	Covered	Covered	—	—	Covered
RUSSIA . .	Covered	Covered	Covered	Covered	Covered
SERB-CROAT- SLOVENE KINGDOM	Covered	Covered	Covered	Covered	Covered

COVERED BY COMPULSORY SICKNESS INSURANCE

Public service 7	Domestic service 8	Home workers 9	Remarks 10
Insured for medical aid only.	Covered	Covered	Col 7 Civil servants, entitled to six months' sick pay, are insured for medical aid only.
—	—	—	
—	Covered	Covered	Col 7. Pensionable civil servants are excluded.
—	Covered	Covered	
Insured for medical aid only	Covered	Covered	Col. 7 Civil servants, entitled to one year's sick pay, are insured for medical aid only
—	—	—	Cols 6 and 7. Railwaymen and civil servants are entitled to sickness pay and medical aid free
—	—	—	Col. 6 Railway staffs are entitled to 120 days' full-pay and 90 days' half-pay during sickness. Free medical aid provided by Nord, P.-O., P.-L.-M., and Etat lines. Medical aid provided by mutual benefit societies on Est, Midi, and Alsace-Lorraine lines.
—	Covered	Covered	
—	Covered	Covered	Cols. 6 and 7 Salaried employees of railways, civil servants and certain employees of local authorities, entitled to equivalent treatment, are excluded
—	Covered	Covered	Cols 6 and 7 Salaried employees of railways are civil servants, entitled to equivalent treatment, are excluded
—	—	—	
Insured for medical aid only	Covered	Covered	
—	—	—	
—	—	—	
Covered	Covered	—	Col 7 Civil servants entitled to equivalent treatment are excluded. Col 9 Insurance may be rendered compulsory by order for owners of undertakings employing not more than three assistants
—	Covered	—	Col. 7. Pensionable civil servants are excluded
—	—	—	Col 9 Insurance may be rendered compulsory by order for home workers.
Covered	Covered	Covered	
Insured for medical aid only	Covered	Covered	Col 4 The process of applying compulsory insurance to agricultural workers is to be completed by 1936.
Covered	Covered	Covered	
—	—	—	
—	—	—	
—	—	—	
Covered	Covered	Covered	
Insured for medical aid only	Covered	Covered	Col. 4. Compulsory insurance for agricultural workers is not yet in force

TABLE II — WORKERS EXCLUDED FROM THE SCOPE OF COMPULSORY SICKNESS INSURANCE
CHARACTER AND DURATION

Country	Age	Working capacity	Income limit
AUSTRIA	—	—	—
BELGIUM (Seamen) .	—	—	—
BULGARIA	—	—	—
CHILE	65 and upwards.	—	Income exceeding 8,000 pesos a year
CZECHOSLOVAKIA . .	—	—	—
ESTHONIA	—	—	—
FRANCE (Alsace-Lorraine)	—	Exemption of invalids at own request	Non-manual workers earning more than 10,000 frs a year
FRANCE (Miners) .	—	—	—
FRANCE (Seamen) . . .	Under 12 or 13.	—	—
GERMANY	—	Exemption of invalids at own request.	Non-manual workers earning more than 3,600 marks a year
GREAT BRITAIN and NORTHERN IRELAND IRISH FREE STATE	Under 16 and for cash benefits over 65	—	Non-manual workers earning more than £250 a year.
GREECE	—	—	—
HUNGARY	—	—	Non-manual workers earning more than 24 million crowns a year.
ITALY (New Provinces) .	—	—	—
JAPAN	—	—	Non-manual workers earning more than 1,200 yen a year
LATVIA	—	—	—
LITHUANIA	—	—	Persons earning more than 400 litas a month
LUXEMBURG	—	—	Non-manual workers earning more than 10,000 frs a year.
NORWAY	Under 15	Exemption of invalids at own request	Non-manual workers earning more than 6,000 crowns a year
POLAND	—	—	Managers earning over 7,500 zloty a year
PORTUGAL	Under 15 and over 75	—	Income exceeding 900 escudos a year
ROUMANIA	—	—	—
RUSSIA	—	—	—
SERB-CROAT-SLOVENE	—	—	—

ON ACCOUNT OF THEIR PHYSICAL AND CIVIL QUALITIES AND THE
OF THE EMPLOYMENT

Employer's family	Nationality	Temporary employment	Occasional employment
(1) Wife or husband (2) Children not paid usual wages	—	—	Persons engaged only occasionally and temporarily in employment
—	Aliens engaged and discharged abroad.	—	—
(1) Wife or husband (2) Ascendants (3) Minor descendants	—	—	—
—	—	—	—
—	—	—	Persons performing work as occasional employment
—	—	—	Occasional workers employed on jobs not lasting more than one week
Members working without agreement or remuneration	—	—	Employment for less than 1 week of persons not ordinarily engaged in paid work.
—	—	—	—
—	All aliens	—	—
Members working without agreement or remuneration	—	—	Employment for less than 1 week of persons not ordinarily engaged in paid work.
(1) Wife or husband (2) Child employed without money payment.	—	Persons casually employed otherwise than for purposes of employers' trade.	Persons casually employed otherwise than for purposes of employer's trade, and certain seasonal agricultural workers
—	—	Persons engaged for casual work.	Persons not customarily but only temporarily engaged on paid work
—	—	—	—
—	—	—	—
—	—	(1) Persons employed for an agreed period of less than 60 days (2) Persons employed by the day up to 30 days.	—
—	—	—	—
—	—	—	Occasional workers whose employment lasts less than 1 month.
Members working without proper appointment and without remuneration	—	—	—
Children living and working at home without fixed money payment.	—	Persons who are not engaged in the trade	—
—	—	—	—
—	—	—	—
—	—	—	—
—	—	Certain seasonal employments	—
—	—	—	Persons who are occasion-

International Tabular

TABLE III — STATISTICS

Country	Year	Total population	Occupied population	Employed population	Number of insured		
					Compulsorily	Voluntarily	Total
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
AUSTRIA	1920	6,131,445	3,124,369	2,520,886	1,046,670	75,332	1,122,002
	1923	6,534,663	3,547,603	2,920,275	2,061,933	72,179	2,134,112
	1924	6,603,588	3,585,088	2,951,143	2,178,825	65,252	2,244,077
	1925	6,639,809	3,604,752	2,967,331	2,225,109	53,590	2,278,699
BULGARIA	1919	—	—	—	—	—	34,720
	1920	4,846,971	2,635,164	408,392	—	—	62,364
	1921	—	—	—	—	—	97,564
	1922	—	—	—	—	—	112,242
	1923	—	—	—	—	—	125,680
	1924	—	—	—	—	—	167,820
	1925	5,081,700	2,761,651	{ 427,994 387,061	241,143	—	241,143
CHILE	1925	3,944,142	—	—	342,500	3,718	346,218
	1926	4,000,000	—	—	496,700	16,533	513,233
	1927	—	—	—	650,000	23,718	673,718
CZECHOSLOVAKIA .	1921	13,599,133	6,053,193	3,908,119	2,249,978	90,713	2,340,691
	1922	13,722,892	6,110,167	3,944,903	2,328,704	114,753	2,443,457
	1923	13,841,321	6,162,898	3,978,948	2,415,409	59,794	2,475,203
	1924	13,985,890	8,227,145	4,020,428	2,635,092	56,655	2,691,747
ESTHONIA	1919	—	—	—	12,047	—	12,047
	1920	—	—	—	14,401	—	14,401
	1921	—	—	—	19,050	—	19,050
	1922	1,107,059	392,039	229,642	25,483	—	25,483
	1923	—	—	—	33,991	—	33,991
	1924	—	—	—	33,561	—	33,561
FRANCE (Alsace-Lorraine)	1919	—	—	—	318,292	23,092	341,384
	1920	—	—	—	362,937	22,369	385,306
	1921	1,695,123	876,799	592,818	365,951	25,030	390,981
	1922	—	—	—	385,719	27,664	413,383
	1923	—	—	—	408,933	30,126	439,059
GERMANY	1914	—	—	—	—	—	16,526,000
	1919	—	—	—	—	—	17,241,000
	1920	59,178,185	29,000,000	23,000,000	—	—	18,780,000
	1921	—	—	—	—	—	19,028,000
	1922	—	—	—	—	—	20,185,000
	1923	—	—	—	—	—	19,999,000
	1924	—	—	—	—	—	19,059,000
	1925	62,348,782	31,985,000	26,035,000	—	—	20,000,000

Summaries: Scope

OF INSURED PERSONS ¹

Total number of insured as per cent. of		Compulsorily insured as per cent. of employed population	Number of persons entitled to medical benefits		Remarks
total population	occupied population		Total	as per cent. of total population	
(9)	(10)	(11)	(12)	(13)	(14)
18.3 32.7 34 34.3	35.9 60.2 62.6 63.2	41.4 70.6 73.8 75	— — — —	— — — —	The 1920 population figures do not include the Burgenland The number of insured includes persons insured under the Workers' Sickness Insurance Act, miners, and agricultural workers Medical benefit for dependants, previously an additional benefit, become a statutory benefit as from April 1927.
— 1.4 — — — 4.74	— 2.4 — — — 8.73	— 15 — — — { 56.34 67.46	— — — — — —	— — — — — —	The smaller figure for the employed population in 1925 includes only workers subject to the Labour Act which does not apply to agricultural workers Medical benefit for dependants is an additional benefit
8.8 12.8 —	— — —	— — —	— — —	— — —	Medical benefit for dependants is optional for each insured person.
17.24 17.81 17.88 19.25	40.32 39.99 40.17 43.23	57.57 59.03 63.02 65.54	— — — —	— — — —	Members of the family assisting the head, who numbered 650,976 in 1921, are excluded both from occupied and employed population. The only public servants included in the number of insured are those employed by the Minister of Railways. All other public servants, who numbered 174,637 in 1924, are, since 1 August 1926, insured for medical benefit, and receive salary for 1 year during sickness Medical benefit for dependants is a statutory benefit.
— 2.30 — —	— 6.5 — —	— 11.08 — —	— 40,187 54,905 71,250 73,140	— 4.96 — —	The only public servants included in the number of insured are workers in State schist quarries, peat diggings and printing office Medical benefit for dependants is an additional benefit.
— 22.9 —	— 44.6 —	— 61.73 —	— — —	— — —	Medical benefit for dependants is an additional benefit. In 1924 83 per cent. of insurance institutions were granting this benefit.
— 31.7 — — — 32	— 64.8 — — — 62.5	— 81.7 — — — 76.8	21,200,000 — — — — 34,300,000	— — — — — 55	The statistics do not distinguish between compulsorily and voluntarily insured. The number of insured does not include public servants excepted on account of equivalent treatment. 300,000 of them are insured voluntarily with private institution Medical benefit for dependants is an additional benefit, but is granted by 80 per cent of insurance institutions

¹ See "General Observations", pp. 162-163.

International Tabular
TABLE III — STATISTICS OF

Country	Year	Total population	Occupied population	Employed population	Number of insured		
					Compulsorily	Voluntarily	Total
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
GREAT BRITAIN . .	1914	41,780,000	—	—	13,600,000	19,000	13,619,000
	1920	—	—	—	—	—	15,234,000
	1921	42,769,000	19,357,319	17,403,000	—	—	15,069,000
	1922	43,062,000	—	—	—	—	15,082,000
	1923	43,399,000	—	—	—	—	15,134,000
	1924	43,629,000	—	—	15,373,000	37,000	15,411,000
	1925	43,783,000	—	—	—	—	15,615,000
	1926	43,970,000	—	—	—	—	15,992,000
HUNGARY.	1924	8,274,940	3,891,564	2,188,000	—	—	963,794
	1925	—	—	—	—	—	—
IRISH FREE STATE.	1926	2,972,802	—	—	450,000	—	450,000
JAPAN.	1920	55,849,000	15,970,000	—	—	—	—
	1923	58,482,000	—	—	—	—	—
	1927	—	—	—	—	—	2,000,000
LATVIA.	1926	1,850,000	—	—	—	—	139,830
LUXEMBURG . . .	1913	—	—	—	43,202	838	40,040
	1919	—	—	—	36,801	918	37,719
	1920	—	—	—	37,495	947	38,442
	1921	—	—	—	37,353	1,006	38,359
	1922	262,684	—	—	42,554	960	43,514
	1923	—	—	—	46,373	801	47,174
	1924	—	—	—	—	—	—
	1925	—	—	—	—	—	—
NORWAY	1913	—	—	—	335,000	3,000	337,620
	1920	2,649,775	1,069,960	708,818	518,000	40,000	558,661
	1921	—	—	—	405,000	53,000	548,250
	1922	—	—	—	511,000	59,000	570,524
	1923	—	—	—	520,000	59,000	579,314
	1924	—	—	—	522,000	62,000	584,800
	1925	2,772,414	—	—	528,000	68,000	596,184

Summaries: Scope

INSURED PERSONS (continued) ¹

Total number of insured as per cent. of		Compulsorily insured as per cent of employed population	Number of persons entitled to medical benefits		Remarks
total population	occupied population		Total	as per cent. of total population	
(9)	(10)	(11)	(12)	(13)	(14)
32.6	—	—	—	—	<p>The number of insured does not include persons excepted on account of equivalent treatment, civil servants, police, railway clerks, and teachers, who were estimated to number 422,000 in 1924.</p> <p>Exempt persons (possessing unearned income) are insured for medical benefit only; they numbered 39,400 in 1924.</p> <p>Medical benefit for dependants is an additional benefit, but is never in fact granted.</p>
35.2	77.8	86.4	—	—	
35.0	—	—	—	—	
34.9	—	—	—	—	
35.3	—	—	15,450,000	35.4	
35	—	—	—	—	
11.65	24.77	44.0	2,170,000	26.2	<p>The employed population includes civil servants, salaried employees, pensioners, manual workers, and domestic servants, engaged in industry, mines, communications, transport, administration and agriculture, but not members of the family assisting the head.</p> <p>The total insured population includes about 2,000 voluntarily insured, and consists of the members of district and works funds, tobacco workers' fund and miners' funds.</p> <p>Civil servants and pensioners to the number of 184,289 in 1924 are insured for medical benefit only, but are not included in the insured population.</p> <p>Medical benefit for dependants is a compulsory benefit.</p>
15.1	—	—	—	—	<p>The number of insured does not include persons excepted on account of equivalent treatment: civil servants, police, railway clerks, teachers.</p> <p>Medical benefit is not an insurance benefit.</p>
3.3	—	—	—	—	<p>The figure for the insured population is based on an official estimate made before the Act came into force in 1927.</p>
7.6	—	—	233,455	12.7	<p>Medical benefit for dependants is a statutory benefit.</p>
16.6	—	—	—	—	<p>Public servants are not covered by insurance.</p> <p>Medical benefit for dependants is an additional benefit.</p>
21.3	52.2	73.1	—	—	<p>The occupied population is the domiciled population aged 15 and over engaged in gainful occupations, not including 547,704 wives and daughters performing household duties.</p> <p>The employed population does not include 83,711 members of the family assisting the head.</p> <p>The number of insured is the membership of district funds, which constitutes 96.97% of the total number of insured under the Act of 6 August 1915. The membership of district and substitute funds in 1925 was 611,095, teachers and railwaymen are insured under special scheme.</p> <p>Medical benefit for dependants is a statutory benefit.</p>
—	—	—	—	—	
—	—	—	—	—	
21.6	—	—	—	—	

¹ See "General Observations", pp. 162-163.

Country (1)	Year (2)	Total population (3)	Occupied population (4)	Employed population (5)	Number of insured		
					Compul- sory (6)	Volunt- arily (7)	Total (8)
POLAND	1926	29,249,000	8,970,000	4,620,000	2,050,000	2,300	2,052,300
ROUMANIA	1924	—	—	—	—	—	997,121
RUSSIA . . .	1924	—	—	7,573,800	6,276,000	—	6,276,000
	1925	—	—	8,763,900	7,631,000	—	7,631,000
	1926	145,906,000	74,000,000	10,545,000	8,795,000	—	8,795,000
SERB-CROAT-SLOVENE KINGDOM	1926	13,027,000	—	—	547,000	2,500	550,000

General Observations on Table III (pp 158-163)

(1) *Total Population* (col. 3).

The statistics of total population are sufficiently homogeneous. Nevertheless, in certain countries they indicate the domiciled population, while in others they refer to the population actually present on the national territory, the difference, however, is hardly appreciable.

(2) *Occupied Population* (col. 4).

The statistics of occupied population are not calculated on exactly the same bases in the various countries. Thus, members of the family assisting the head are sometimes included, sometimes not. This group constitutes an important fraction of the population, especially in agricultural countries where smallholdings are the rule. The proportion of the occupied to the total population is largely affected by the inclusion or exclusion of this group. Wherever information has been available on this point, it has been given, but unfortunately it was lacking for several countries.

(3) *Employed Population* (col. 5)

The statistics of employed population, i.e. persons who hire their services to an employer for remuneration, are sufficiently homogeneous. Nevertheless there is divergence as to the inclusion of the managers of undertakings and home workers; moreover, civil servants, who are engaged by nomination and not by contract, may sometimes be excluded.

It must be observed that the proportion of the employed population to the occupied and total population depends in agricultural countries largely upon the size of the farms, and on the number of *métayers* and peasants, who are not counted as employed persons.

Summary: Scope

INSURED PERSONS (*continued*)

Total number of insured as per cent of		Compulsorily insured as per cent. of employed population	Number of persons entitled to medical benefits		Remarks
total population	occupied population		Total	as per cent of total population	
(9)	(10)	(11)	(12)	(13)	(14)
7	22.9	44.4	4,912,300	16.8	Some civil servants are insured under the general system and are included in the number of insured but others are insured for medical benefit only. The number of the latter group is not known, but with their dependants they are estimated at 400,000, which is included in the number of persons entitled to medical benefit. Medical benefit for dependants is a statutory benefit.
—	—	—	—	—	The total number of persons includes all persons insured in the entire Kingdom (Former Kingdom, Bessarabia, Ardeal, Bukovina).
— — 6.0	— — 12	83 87 88	— — —	— — —	
4.2	—	—	—	—	Civil servants are insured for medical benefit, but their number is unknown. Medical benefit for dependants is a statutory benefit.

(4) *Statistics of Insured Persons* (cols. 6, 7, 8).

The statistics of insured persons only include civil servants and railwaymen when the risk of insurance in their case is covered by an insurance scheme, which sometimes comprises both benefits in kind and cash benefits, but more often medical benefit only. Civil servants and railwaymen who are outside any insurance scheme but are entitled in case of sickness to the continuance of their salary are not included in the statistics of insured persons.

The statistics of voluntarily insured persons only cover persons voluntarily insured under conditions prescribed in compulsory insurance laws.

(5) *Ratio of Insured to Total, Occupied and Employed Population* (cols. 9-11).

By reason of the differences, sometimes considerable, in the methods of calculating the insured, total, occupied, and employed population, the ratios between these various quantities are not always comparable.

Moreover, the highest percentages do not necessarily indicate the highest development of workers' insurance, the maximum scope of which depends upon the importance of the employed population in relation to the total population. Hence the percentage will naturally be smaller in countries which possess a large class of persons working on their own account, and especially in countries where *métayers* and peasants are numerous.

(6) *Statistics of Persons Entitled to Medical Benefit* (cols. 12, 13).

Compulsory sickness insurance is tending to grant to members of the family of insured persons various benefits, and especially medical benefit. It has been thought of interest to indicate this extension of the field of activity of insurance schemes by giving statistics of the entire number of persons whose risk is wholly or partly covered by insurance: dependants, railwaymen, and civil servants, as well as insured persons. Unfortunately such figures are only available for a few countries.

PART II

B E N E F I T S

PART II

BENEFITS

INTRODUCTION

THE PURPOSE OF INSURANCE

If social progress consists in the increase of security, in clearer vision of the future, and in the fuller satisfaction of wants, social insurance, by the system of benefits which it affords, will have an important function to perform in the general movement to create for the workers a condition of greater economic security.

Man has at all times a great variety of wants, and upon his ability to satisfy them depends the success of his existence. The nature and scale of his wants differ from age to age and from country to country, and alter as he passes from one stage of his career to another. Some wants arise periodically and normally, while others arise in emergencies which occur to individuals from time to time and require satisfaction of a special character. In order to meet his regular needs, a man must generally rely upon his own resources, and is responsible for the success or failure of his enterprises. This isolation is only broken down by the gradual elaboration of social organisation.

Social insurance protects the people against the economic consequences of the hazards under the menace of which they live and labour. The special purpose of sickness insurance is to ward off or mitigate dangers, resulting from the weakness of the human constitution, by means of benefits corresponding to the wants and the risks which it covers.

THE RISKS COVERED

Sickness as a possibility is constantly present with everybody: for the body is subject both to natural decay and to

functional disorders, whether external or internal in their origin. A state of disease calls for treatment in order to prevent aggravation and to restore to health. If the patient, while under treatment, can continue his usual occupation, the only need arising from the illness is that of medical aid, but often the patient is obliged to suspend his working activity and thereby, in the case of a wage-earner, to lose his means of subsistence. Hence for the majority of workers sickness represents a double risk: that of disease necessitating treatment and that of cessation of income through inability to continue at work.

Sickness insurance however is not limited in its functions to caring for the needs of insured persons suffering from bodily or mental disease: it regards also the needs of mothers and children. Maternity is indeed a normal physiological process as long as it is not accompanied by pathological symptoms. Nevertheless, so important is this biological function for the maintenance and quality of the race that it behoves society to see that it is accomplished under proper conditions. In many countries the risk of maternity is covered by sickness insurance.

A third risk against which sickness insurance in a large number of countries must provide is that of funeral expenses, for which the deceased's survivors are liable.

The three contingencies of sickness, maternity, and death may happen to the person insured, to protect whom alone was originally the business of insurance. Nevertheless, it has been found impossible to disregard the fact that the insured person is also a member of a family, and that as such he is closely affected by the sanitary conditions of his home life. A comprehension of the dependence of the health of the insured upon that of his family has caused insurance to be extended to cover the risks not only of the insured himself but also of his dependants.

THE NATURE OF THE WANTS ARISING IN SICKNESS

According to its gravity, a case of sickness should call into play action to preserve life, avoid aggravation, localise and render tolerable the symptoms, restore the patient to a condition where he no longer needs treatment, and enable him to resume his normal existence. Cure generally involves the attention of a doctor and sometimes a surgeon or specialist, the administration of medicines and other curative means, and the services of a nurse. Moreover,

the nature of the disease or the circumstances of the patient's home may necessitate his removal to hospital, or it may be that to complete the course of treatment baths or residence in a convalescent home are required.

Besides medical treatment and the provision of drugs, however, a wage-earner who has to cease work on account of illness stands in need of resources to replace the wages which he is losing and upon which he and his family depend. This need is the more urgent the shorter the interval between the receipt of wages and the consumption of their proceeds.

Maternity, like an illness, is the occasion of abnormal wants. It creates a need for treatment and for a substitute for the earnings lost by the mother.

In her own interest and in that of the child, the mother requires before confinement to abstain from work, and during confinement she needs the care of a midwife or a doctor, according to circumstances. A layette must be provided for the new-born child. During the weeks following birth and while the child is being nursed, it is necessary to maintain mother and infant in proper hygienic conditions. In order that the mother, if a wage-earner, may leave her work without incurring economic loss, she must be supplied with resources to replace her wages.

Death entails the expenses of a funeral at the very moment when the household of the insured is subject to severe economic strain.

The character of insurance benefits must be adapted to these different kinds of needs.

THE NATURE OF THE BENEFITS

Two alternative policies may be followed in determining the nature of sickness insurance benefits. The first consists in granting the insured person a benefit in cash so that he may himself obtain the goods and services he requires, while according to the other the insurance institution is entrusted with the function of organising the provision of whatever is needed by the insured.

The first policy is of an individualist character, since it leaves to the beneficiary the responsibility for choosing the means of satisfying his wants. He receives a sum of money and procures in exchange for it medical aid and food, employing the money as he likes. The insurance institution, for its part, has discharged

its duty as soon as it has granted the money, so that the insured person runs the risk of the benefit being insufficient for his needs.

If, however, the administration of benefits is organised by the insurance institution, the latter is responsible for relieving the economic and physiological distress of the insured by placing at his disposal the goods and services which he requires. The patient is provided with medical treatment and medicine, and is maintained at the expense of the institution in a hospital or convalescent home. If he has no voice in the disposal of the benefit, the patient is at least free from the anxiety of seeking proper means of utilising it. The insurance institution must get for him what he needs, and must adjust the benefit to his individual requirements.

In the present state of the development of social insurance neither of these policies is followed exclusively, but it may be affirmed that benefits in kind are becoming more important than benefits in cash. Early in its career sickness insurance directed its efforts mainly to insuring to sick persons unable to work a payment to replace the earnings lost, and only to a small extent did it endeavour to restore their health: only later was the importance of the task realised which sickness insurance was called upon to perform in the public health system. For the fact is that sickness insurance, better than any other instrument of social welfare, is fitted to assist, by organising medical treatment, in improving the health of the population. Henceforward the principal business of sickness insurance is to put at the service of every insured person a proper scheme of medical aid. Slowly and gradually benefits in kind increase their importance in relation to cash benefits. To effect the thorough and rapid cure of illness which prophylaxis has been unable to prevent has now become the central aim of every sickness insurance scheme. The cash benefit intended to relieve the more pressing economic needs of the patient becomes a mere supplement to medical aid.

* * *

The subject of this Part of the volume is that of sickness insurance benefits, the study of which is divided into seven Chapters. The first three are concerned with cash benefits, the next three with benefits in kind, and the last with the organisation of the service of benefits by insurance institutions.

Cash benefits consist in the award to the beneficiary of a sum of money with which to buy a certain quantity of goods and services. The chief cash benefit, which is sickness benefit, is intended to

compensate, at least partially, for the economic loss incurred by the insured when absent from work. In order to be entitled to this benefit, the patient generally has to comply with certain conditions. He must have belonged to the insurance institution for a minimum period, must not without due reason leave the area of the institution, must notify his incapacity in the prescribed form, and must obey the instructions of the institution as to behaviour during sickness. These conditions for the receipt of benefit are described in the first Chapter. The insured person who fulfils the requirements has a right to the benefit. The amount of the benefit is fixed by law, and the insured person is sure of receiving the minimum benefit which the law prescribes. He enjoys the benefit, however, only for a certain period, the maximum duration of which is also fixed by law. In certain circumstances the sickness benefit may be replaced by the award of some other advantage, while in others it may be reduced because the wants of the patient are less. Further, insurance institutions may, by the economical management of their resources, be able to afford to increase the rate of benefit and to prolong the period during which it is payable. The second Chapter deals with the amount and duration of sickness benefit. In a large number of countries it is the business of sickness insurance to cover the funeral expenses of the insured and his dependants, and the third Chapter is devoted to funeral benefit.

It is in benefits in kind that insurance institutions are chiefly interested nowadays. All sickness insurance laws admit the more or less extensive right of the patient to medical treatment and medicines. Besides the minimum thus insured, it is generally permissible for insurance resources to be applied to the provision of medical aid in a form more appropriate to the needs of the patient, or of additional benefits in kind. In the fourth Chapter will be examined the questions connected with benefits in kind. The wage-earner who is the father of a family runs the risk of sickness not only in his own person but in that of his dependants living in the household. The illnesses from which his dependants may suffer impose upon the wage-earner an expense in the shape of the cost of medical attendance and medicine, and moreover they endanger the health of the entire family including the head, who may thus be rendered incapable of earning. Hence the question of medical aid for dependants is of the greatest social importance, and provisions to this effect are included in sickness insurance schemes. These provisions form the subject of the fifth Chapter. Furthermore, sickness insurance, as has been stated already, covers the

risk of maternity and secures that the confinement shall take place under proper conditions of hygiene. The sixth Chapter deals with maternity benefits.

Insurance institutions responsible for benefits in kind are bound to organise the administration of these benefits. They must supply medical treatment and medicines, accommodate their patients in hospitals and care for the delicate and convalescent. They must arrange for the services of qualified practitioners and pharmacists and for hospital accommodation. Two methods of organisation are available, which may be applied together or as alternatives. One plan is that the institutions should use the existing medical personnel and equipment of the country, and arrange with doctors, chemists, and hospitals to put themselves at the disposal of the insured. The second method is for the institutions to employ their own doctors and provide their own equipment of dispensaries, hospitals, and homes, though in accordance with the general regulations concerning the practice of medicine. The complicated subject of the organisation of medical service by insurance institutions is treated in the seventh and final Chapter.

CHAPTER I

CONDITIONS OF BENEFIT

The object of sickness insurance benefit is to compensate, at least in part, for the loss of income suffered by an insured person owing to the incapacity for work produced by sickness. The insuring group comes to the assistance of the member who is compelled by sickness to stop work. Sickness benefit is the principal cash benefit offered by sickness insurance. All systems of compulsory insurance (except that of Basle Town) guarantee its payment to sick persons who are unable to work, the amount and duration of the benefit being defined by the law.

The very purpose of the benefit determines the general condition on which it is granted: that the insured person must be unable to continue carrying on his occupation owing to sickness. The condition requires some further definition, to show whether it covers every sickness and all forms of incapacity for work, and how the incapacity for work is proved.

This first condition is supplemented by others more or less restricting the right to benefit.

An insured person is not necessarily entitled to cash benefit as soon as he enters into insurance. Some insurance systems fix a *minimum period of membership*; before an insured person acquires the right to cash benefit, he must have performed his obligations as a member for a certain period. Only a member who has qualified by a certain period of membership, or even by a financial contribution to insurance, may become a claimant for benefit.

There is another condition contained in many laws. A sick person who wishes to claim benefit must not leave the area of the insurance institution without valid reason on pain of having his right to benefit suspended or reduced. The point is that the insurance institution responsible for paying benefit cannot be required to maintain administrative and supervisory authorities outside its area, or therefore to pay benefit wherever the sick person may choose. The benefit is therefore subject to *residential conditions*.

Even if the other conditions are fulfilled, an insured person is not entitled to benefit on the first day he loses his capacity for work. In order to prevent abuses and to avoid overburdening insurance institutions with the payment of benefits for short terms of disablement, the insured may not claim benefit unless the incapacity for work has lasted for several consecutive days, constituting the *waiting period*.

Thus membership does not necessarily give a right to benefit from the outset. On the other hand a person with certain qualifications may retain his right even after ceasing to belong to the insurance system. Thus persons formerly insured may under certain conditions claim benefit if they fall ill during a relatively short period after they left off being insured (period of protection).

The principal conditions of benefit — incapacity for work, period of insurance, waiting period, residential conditions — will be discussed in turn.

§ 1. — Incapacity for Work

Sickness benefit is payable to insured persons who are unable to work owing to sickness. This necessitates an examination of the definitions of sickness and incapacity for work and of the manner of proving incapacity.

SICKNESS

For the purpose of insurance legislation, sickness is any abnormal mental or physical condition which necessitates treatment or the suspension of work, or both. A pathological phenomenon is not in itself sufficient to constitute sickness as defined by insurance. It must also make the person unable to work, or call for treatment. The ætiological origin of the complaint is unimportant from the insurance point of view. It does not matter whether the abnormal state of health is due to external agencies, organic or functional disturbances, or normal physical wear and tear. The disturbance to health is of no interest to insurance unless it is of a given severity. The symptoms must be such as to justify a belief that the state of health will become worse if the sick person is not treated or does not stop work. On the other hand it is not sufficient if all that is required is simple care. The very summary legal provisions on this point leave it open to administrative and legal practice to

draw the line between normal and abnormal states and between complaints of some severity and negligible symptoms.

As a rule the cause of the disease does not affect the right to benefit, which exists whether the cause is known or not, whether it can be attributed to the action or negligence of third parties or the sick person himself, to his occupation or conditions of life, or to mere chance. Nevertheless, several laws take the cause of sickness into account if it lies in an industrial accident or an act which is a punishable offence or has been performed wilfully in order to produce sickness.

Sickness Due to Industrial Accidents

In accordance with the principle of occupational risk ¹ the large majority of laws establish the contractual or limited liability of the employer or a group of employers for the consequences of accidents suffered by the persons they employ during the course of their work. The question therefore arises what the liability of the sickness insurance institution will be towards the victim of an accident: whether it will remain unchanged or be reduced, or even disappear altogether.

This problem does not arise if the same insuring group intervenes, whatever the cause of the sickness; there is only one undivided liability. Thus in the Russian system it is immaterial what causes the need for medical treatment or the incapacity for work, and the liability of the insuring group is the same whether the sickness is occupational in origin or not.

When the sickness insurance institution and the accident insurance institution or employer are both liable, the former institution may nevertheless remain solely liable so far as the victim of an accident is concerned. This is the position under Austrian, Czechoslovak, Luxemburg, and Polish law, according to which the sickness insurance institution may not claim that the origin of the sickness is occupational and must consequently pay the insured all the prescribed benefits. On the other hand, it has the right to claim from the accident insurance institution or employer the total or partial repayment of its expenses. In Austria, a sickness fund which has paid benefit during a period for which the member

¹ Cf. INTERNATIONAL LABOUR OFFICE *Compensation for Occupational Diseases*. Studies and Reports, Series M, No. 3. Geneva, 1925.

is entitled to accident compensation may require the accident insurance institution to refund up to the amount of the benefits paid, and it alone has the right to establish the claim transferred to it by the law. In Czechoslovakia the claim of the victim of an accident to compensation is transferred to the sickness insurance institution up to the amount of the benefit paid by the latter, or in full if such benefit exceeds the compensation, and the institution may then claim from the accident insurance institution. Similarly, in Luxemburg a sickness fund which has paid benefits to a member who is entitled to accident compensation may claim from the accident insurance institution the repayment of all the benefits granted. In Poland, the sickness fund pays benefits even for sickness covered by accident insurance, but the accident insurance institution or employer must repay to the fund the total cash benefits it has paid, half the basic wage in repayment of hospital expenses and three-eighths of the basic wage in repayment of medical expenses.

Under certain other laws the obligations of the sickness insurance institution in the event of accidents to its members are somewhat increased, the responsibility of the two institutions being divided between them on a time basis. The sickness fund may claim from the accident insurance institution only the repayment of benefits granted after a certain period after the accident has elapsed. Thus in Germany, the sickness fund may claim only the repayment of the cash benefit granted after the eighth week following the accident, and it is definitely responsible for benefits in kind for all accidents involving incapacity for work of eight weeks or less. In the Serb-Croat-Slovene Kingdom all the costs arising out of sickness benefit and medical treatment after the fourth week following the accident are met by the accident insurance institution, all costs up to the beginning of the fifth week being definitely defrayed by the sickness insurance institution.

The liabilities of sickness insurance institutions for the consequences of accidents in Great Britain and Ireland are very limited, if they exist at all. If an insured person has obtained, or is entitled to, compensation under the Workmen's Compensation Act or the Employers' Liability Act, or under the common law, the weekly sickness or disablement benefit is only payable in so far as it exceeds in amount the weekly value of the accident compensation. If the insured person refuses to sue for compensation, the sickness insurance institution may itself take action on his behalf.

Sickness Wilfully Induced

As a rule there is no right to sickness benefit in the case of sickness wilfully induced by an insured person, or contracted in consequence of a punishable action, especially one directed against the insurance institution. The refusal to grant sickness benefit may be prescribed in the law itself, or else it is or may be established by the rules of the institution.

The Czechoslovak, Estonian, Hungarian, Latvian, Lithuanian, Norwegian, and Yugoslav laws refuse benefit in cases of disablement due to wilfully induced sickness. Moreover, the Czechoslovak and Norwegian laws refuse it if the sickness is the direct result of drunkenness, and the Czechoslovak, Estonian, Latvian, and Lithuanian laws if it is due to culpable participation in a brawl or quarrel.

A total or partial refusal of benefit may be fixed by the rules of the institution for all insured persons, without appeal to the fund, in the following countries: in Austria, for insured persons who have wilfully induced their sickness by culpable participation in a brawl, or whose sickness is the direct consequence of drunkenness; in Germany, for insured persons who have produced their sickness wilfully or by culpable participation in a brawl; in Luxemburg, for persons suffering from a sickness induced wilfully or caused by reprehensible participation in a quarrel or brawl, and for persons who have injured the fund by an action liable to involve a loss of civil rights for one year from the date of the offence. In Great Britain, the sickness benefit may be suspended or limited if the disablement is attributable to the misconduct of the insured person; the rules of most approved societies provide for the suspension of the benefit if the disablement is due to misconduct, which term would include poisoning, foolhardiness, or wilful mutilation.

In the following countries the law empowers the insurance institution to refuse or reduce sickness benefit in specified cases: in Bulgaria, if the sickness was knowingly produced by drunkenness or other vice; in Poland, for insured persons guilty of producing their sickness deliberately or by participation in a brawl or having injured the fund by a punishable action; in Russia, for temporary incapacity lasting less than three days and caused by drunkenness.

It should be observed that the refusal relates only to cash benefit and not to benefits in kind, in particular medical treatment. Otherwise the weapon of the insurance institution against guilty members would be found to cut both ways.

INCAPACITY FOR WORK

If the sickness is to give the right to benefit, it must entail incapacity for work. A sick person is considered unable to work if he cannot continue to perform his regular work, or can do so only at the risk of aggravating his condition. It is sufficient if the incapacity relates to the occupation ordinarily engaged in, and a sick person cannot be required to undertake remunerative work in a trade other than his own. Further, it is immaterial whether the incapacity for work is total or partial, provided that the sick person is in fact unable to work without running the risk of aggravating his condition. In this respect there would not appear to be wide differences in administrative practice, which is based on the instructions of the central authorities and judicial practice. As an example, the criteria applied in Germany and Great Britain may be given.

In Germany "a person is considered unable to work if he cannot continue to follow his former occupation or can do so only at the risk of aggravating his condition. The incapacity is considered to exist even if the sick person might earn his living by undertaking other work, and this is so even where the new work would be in accordance with his strength and skill and might reasonably be asked of him in view of his previous training and occupation."¹ In judicial practice it is considered sufficient that there should be a danger of aggravating the sickness, provided that this danger is not too remote. A sick person cannot be required to accept employment outside his trade, and the incapacity for work is still considered to exist even if he were able to find work in the general labour market.

In Great Britain an insured person is considered unable to work if an attempt to work might seriously injure his health. Although a person considered temporarily unable to follow his occupation is not necessarily unfit for other work, he is considered unable to work if it is likely that he may soon resume his former occupation². In brief, in cases of short-period incapacity only the normal occupation of the insured person is taken into account, whereas for the payment of disablement benefit account is also taken of the other occupations in which he might reasonably be expected to engage³.

¹ *Explanatory Memorandum to the Social Insurance Code*, pp. 155, 166

² *Approved Societies' Handbook*, 1925, Sections 310 and 311.

³ ROYAL COMMISSION ON NATIONAL HEALTH INSURANCE: *Evidence*. Appendix, Part I, p. 17

PROOF OF INCAPACITY FOR WORK

The fact of being disabled for work by sickness is not in itself sufficient to give a right to benefit. The insurance institution must also be informed in the prescribed manner. To this end the sick person must furnish the insurance institution with a medical certificate attesting his incapacity. A medical certificate is naturally the usual and most appropriate form of proving incapacity for work, but since for the purpose of insurance legislation incapacity is not a medical but an economic conception, it is usually open to the insured to supply any other form of proof of their incapacity for work, and to the insurance institutions to dispense with a medical certificate.

The benefit is intended to take the place of the wages lost owing to sickness. In some countries, such as Hungary and Japan, the law does not grant benefit to persons who continue to receive all their wages during sickness, and if they continue to receive part of their wages, this part together with the benefit must not exceed the full rate of sickness benefit. Certain other laws, however, do not prescribe a reduction in sickness benefit if the sick person can claim all or part of his wages, but provide for such reduction by the rules of the insurance institutions¹.

§ 2. — Minimum Period of Membership

An insured person is not necessarily entitled to benefit on the date of admission to an insurance institution. Certain laws, with a view to shielding the insurance institutions against exploitation by persons already suffering from sickness when admitted, have followed the rules of private insurance and require the insured person to undergo a qualifying period, that is to say, to belong to the insurance institution and fulfil his financial obligations arising out of membership for a minimum period.

COMPULSORY INSURANCE

A large number of compulsory insurance laws do without the minimum period of membership on the ground that the insured

¹ See pp. 206-208.

persons could not have belonged, as compulsorily insured members, to an institution before they engaged in an occupation rendering them liable to insurance, and that they are not directly responsible for the payment of their contributions. Thus, there is no qualifying period for compulsorily insured persons in Austria, Czechoslovakia, Esthonia, France (Alsace-Lorraine), Germany, Hungary, Japan, Latvia, Norway, Poland, Russia and the Serb-Croat-Slovene Kingdom. In some of these countries, however, temporary workers may be required either by the law or the rules of the institution to undergo a qualifying period. This is so in Austria for persons employed simultaneously or successively by several employers and for temporary workers, in Germany and Latvia for temporary workers, in Poland for homeworkers and temporary workers.

It is by no means always the case, however, that a compulsory insurance law does not require a minimum period of membership. Thus in Bulgaria, Chile, Great Britain, the Irish Free State, Luxemburg, Portugal, and Roumania persons who join an insurance institution are not immediately entitled to sickness benefit. Under the British and Irish laws an insured person cannot claim any sickness benefit at all until 26 weeks have elapsed since he became insured and unless at least 26 weekly contributions have been paid on his account; for the payment of sickness benefit at the full rate 104 weeks of insurance and the payment of 104 weekly contributions are required. In Bulgaria the minimum period of membership for compulsorily insured persons is not less than eight consecutive weeks, in Chile seven months, in Portugal six months, in Luxemburg eight days, and in Roumania six weeks. In Lithuania no period is fixed by the law, but the funds may introduce one by their rules.

VOLUNTARY INSURANCE

For voluntarily insured persons a qualifying period may be said to be general. Here a distinction may be made between the compulsory period fixed by the law and capable of extension by the rules and the period which may be fixed by the rules with the authority of the law. A qualifying period is compulsory in Czechoslovakia and Poland (not less than four and not more than six week) and Luxemburg (not less than ten days), as well as in Latvia in the case of independent craftsmen (between two and six weeks, as the fund decides); it is only optional in France (Alsace-Lorraine) and Germany (not more than six weeks).

PERIOD OF PROTECTION

In principle sickness benefit is payable only to insured persons who have fulfilled any requirements as to minimum period of membership. Nevertheless, even after passing out of insurance, a person may retain his rights for a relatively short period. During this period of protection a former member may still benefit by the privileges granted to actually insured members. Several laws provide for such a period of protection for those former members who become unemployed, and the British and Polish laws also for other former members. In Great Britain and the Irish Free State any compulsorily or voluntarily insured person may claim all the prescribed benefits during the year following the week in which he ceases to be employed in an occupation involving the liability to insure or in which his last voluntary contribution was paid, if he becomes unable to work during this period (free year). A similar but more limited provision is to be found in the Polish Act. An insured person who leaves his employment after belonging to a fund for at least the six previous weeks or for 26 weeks in the course of the previous 12 months, retains his right to benefit during a period fixed by the rules, on condition that his sickness occurs within four weeks of giving up the employment.

Other laws establish a period of protection only for formerly insured persons who become unemployed and continue to live in the country. Thus, in Austria insured persons who fall out of work retain the right of benefit for not more than six weeks, and in Esthonia and Latvia for a month. In Czechoslovakia an insured person who has no earnings, is not in receipt of a pension, and lives in the Republic is entitled to sickness benefit and other benefits if the sickness occurs within a period equal to the last continuous period during which he performed work entailing liability to insurance, up to a maximum of six weeks.

In Germany, an insured person who leaves his fund on account of unemployment and has belonged to it for at least 26 weeks, or for the six weeks immediately preceding his leaving, retains his right to ordinary benefits if the sickness occurs during his unemployment and within three weeks of his leaving. In Hungary and the Serb-Croat-Slovene Kingdom, the period during which benefit may be paid is three weeks if the unemployed worker had been insured for at least six months during the past year, and six weeks if he had been insured for at least 12 months during the last two

years. In Luxemburg an insured person who becomes unemployed retains his right to ordinary benefits if he has been insured for a specified period and the sickness occurs within three weeks of his passing out of insurance.

§ 3. — **Waiting Period**

As a rule a sick person who becomes unable to work cannot claim sickness benefit as from the first day of disablement. The economic consequences of short periods of indisposition are not sufficiently serious to interest the insurance institution. Almost all laws lay down that benefit cannot be claimed until after a certain waiting period. There are various arguments in favour of such a provision.

During the first few days of incapacity for work an insured person is considered able to support himself out of his own resources, especially if the indisposition is soon over so that he can resume his work. Moreover, certain groups of workers paid by the month or week are often entitled to sick pay under the law or their contract of work for short periods of indisposition due to sickness which is not wilfully induced nor the result of grave negligence. In some countries this right is granted, unless otherwise agreed, to all persons who have worked for a specified period with the same employer.

For the insurance institution the obligation to pay benefit for sicknesses lasting only a few days would be costly and difficult to fulfil. Short indispositions are frequent, and the institution would be overwhelmed with claims for benefit which, if accepted, would seriously increase its expenditure. The cost of examination and especially of supervision would be out of all proportion to the social service rendered to the insured.

Lastly, there is a psychological argument in favour of establishing a waiting period. It is not desirable to induce too great a sentiment of security among the insured by relieving them of their economic responsibilities, even for very short interruptions of work.

Although a waiting period is established by almost all laws, the position of the insured differs according to the nature and duration of the period.

NATURE OF WAITING PERIOD

The waiting period may be absolute or relative. In the first case the sick person acquires the right to benefit only at the end of the period and irrespective of the total period of incapacity; in other words, the financial losses due to incapacity during the days of the waiting period are definitely borne by the insured. When the waiting period is relative, the sick person is similarly unable to claim benefit for indisposition of shorter duration than the period, but for longer periods of incapacity for work he becomes entitled to benefit with retrospective effect as from the first day of disablement.

Moreover, the waiting period may be both absolute and relative, that is to say, absolute for a first short period of incapacity and relative for a longer incapacity, besides which the benefit may be paid retrospectively either from the first day of incapacity or from a subsequent day though previous to the end of the absolute period.

When a relapse occurs within a specified period after the first attack of sickness, the waiting period is generally not applicable.

DURATION OF WAITING PERIOD

The minimum waiting period varies between one and four days.

The absolute waiting period is four days in Italy (new provinces); three days in Esthonia, France (Alsace-Lorraine), Germany, Great Britain, the Irish Free State, Japan, Latvia, Lithuania, and Norway; two days in Hungary, Luxemburg, and Poland.

The waiting period is relative in the Austrian and Czechoslovak Acts, which grant benefits as from the first day of disablement if the incapacity lasts for more than three consecutive days. If it is shorter, the sick person receives no benefit. If it continues on the fourth day, he acquires on that day the right to benefit also in respect of the three preceding days.

Finally, the waiting period is mixed in Chile, Czechoslovakia, and Roumania (former Kingdom). When the disablement lasts less than four days in Chile, three days in Czechoslovakia, and two days in Roumania, there is no right to benefit. If it lasts over seven days in Chile and Roumania, benefit is due retrospectively from the first day, whereas in Czechoslovakia a retrospective claim applies only for disablement lasting more than 14 days, and then only as from the third day.

No waiting period is enforced in Bulgaria, Portugal, and Russia.

It may be added that many laws empower the insurance institutions to suspend or reduce the waiting period for all or certain diseases. Moreover, some laws do not apply the waiting periods in cases of sickness due to industrial accidents.

§ 4. — Residential Conditions

The insurance institution possesses administrative and supervisory machinery for carrying out its obligations towards the insured. It would be unreasonable to require it to set up such machinery in other places than those where the insured usually live and are to be found in fairly large numbers. Thus as a rule the insurance institution is not bound to pay benefit outside its district, which, according to the nature of the institution, may cover a smaller or larger part of the area of the State or even its whole territory. There are, however, important exceptions to this principle, in the interests of those insured persons who are involuntarily outside the area of their fund and have neglected nothing for making use of the organisation placed at their disposal by the insurance institution.

Before an examination of the degree of strictness of the residential conditions imposed on the insured, it may be pointed out that for the sick persons within the area of the fund the only question is whether the benefit shall be paid to them at home at the risk of the institution, or whether on the contrary they are to fetch it themselves at the place designated by the fund, or finally whether the benefit is to be sent to them at their risk and cost. In the German and many other Continental systems, the sick person must himself provide for fetching the benefit at the offices of the fund, but in Great Britain the costs of delivery are met by the insurance institution, which also bears the risk.

For insured persons living outside the area of the insurance institution, the position differs according as they live in the country itself or abroad.

PERSONS LIVING IN THE COUNTRY BUT OUTSIDE THE AREA OF THE INSURANCE INSTITUTION

In countries with a centralised system of insurance forming only one accounting unit, the insured, so long as they do not leave the country, are deemed still to belong to the system. There is

therefore no reduction in their claim to benefits. In this respect, and in spite of the absence of any territorial organisation of the insurance system, the position of the insured is altogether the same as in Great Britain, where the network of branches and agencies of approved societies and the uniform rate of benefit facilitate payment wherever the recipient may be.

On the contrary, in countries with a large number of insurance institutions, of different types and with financial independence, the rights of the insured persons outside the area of the fund are subject to certain conditions. Three cases may be distinguished.

The sick person may live outside the area of his fund. In this case the insurance institutions are generally bound to help each other. Thus, in France (Alsace-Lorraine), Germany, and Luxemburg the competent fund must request the fund for the place of residence of the insured person to pay him benefits at its cost. But this method, which is favourable to the insured, is not adopted in all laws.

The insured person may fall ill while staying outside the area of the fund, though still in the country. Here, too, the insured person usually obtains benefit from the fund for his place of residence. It is paid either on the request of the competent insurance institution or even without such request, during the whole period of the residence of the sick person, or only during the period in which he is prevented by illness from returning home. These methods are adopted with certain differences in Austria, Czechoslovakia, France (Alsace-Lorraine), Germany, Luxemburg, Norway, Poland, Portugal, and Russia.

The sick person may voluntarily leave the area of the fund after the sickness begins. In this case he cannot usually claim sickness benefit, but if the insurance institution can check his state of health, it may arrange to send the benefit to his representative at the cost and risk of the latter.

PERSONS LIVING ABROAD

Here, too, a distinction may be made between three cases.

The insured person falls ill abroad. A method adopted fairly often, for instance in France (Alsace-Lorraine), Germany, Hungary, Norway, and the Serb-Croat-Slovene Kingdom, is that the employer must pay the benefit so long as the sick person cannot return to his own country. The employer is entitled to repayment if he

notifies the fund within the prescribed period, unless the fund itself provides for the payment of benefits.

The sick person goes abroad with the consent of the insurance institution. In this case the right to benefits, and in particular sickness benefit, remains. But in certain laws, such as those of Germany and Luxemburg, the institution may free itself of its obligations by a capital payment corresponding in value to the probable claim of the sick person to benefits according to the duration of the sickness.

The sick person goes abroad voluntarily without the consent of the insurance institution. In this case the payments are suspended for the whole period of the stay abroad unless the institution subsequently gives its consent. In this connection it should be pointed out, however, that a stay in certain frontier districts is not considered as a stay abroad.

§ 5. — National Laws: Summary of Provisions on Conditions of Benefit

AUSTRIA

ACT OF 30 MARCH 1888: NEW TEXT PROMULGATED BY THE ORDER OF
20 NOVEMBER 1922

Qualifying Period

The right to sickness benefits commences on the date on which the insured person becomes a member of the fund (section 22). Membership of the fund is acquired on the date the person in question enters an employment rendering him liable to insurance (section 13, subsection 1).

An insured person employed simultaneously or in succession by more than one employer does not acquire membership until he has been recorded in a special register. For such persons the rules of the fund may fix a qualifying period of not more than four weeks. A similar provision applies to temporary workers (sections 26 and 33 of the Act of 21 October 1924, B & Bl., No. 581).

Waiting Period

The insured person is entitled to benefit if the loss of working capacity lasts more than three days as from the beginning of the incapacity (first day of sickness). If the first or last day of the sickness is a holiday, it is not taken into account (section 6 (2)).

The funds have no right to lay down in their rules that the sickness benefit shall not be due as from the first day of sickness but from the day on which the insured person notifies it (Administrative Court, No. 4,945 of 21 May 1909). The rules may provide that sickness benefit shall be granted for sicknesses of three days or less (section 9, subsection 3).

Residential Conditions

The Act does not refuse insured persons who are outside the area of the fund the right to claim sickness benefit. But the funds may impose certain restrictions on such persons. Thus the rules may provide that for sick insured persons who live outside the area of the fund during their sickness, the benefits in kind may be replaced by an increase in the cash benefit (section 9 c, subsection 1 (1)).

Period of Protection

The members of a fund who become unemployed retain their right to benefits, even without paying contributions, for not less than six weeks on condition that they live in Austria. After this period unemployed persons are entitled under unemployment insurance legislation to sickness insurance benefits if, when the event giving rise to the claim to benefit takes place, they are in receipt of statutory unemployment benefit or are temporarily excluded from it under section 3, subsection 3, or sections 5, 7 or 13 of the Unemployment Insurance Act. They have no right to sickness benefit for the period of such exclusion or for the period during which they have already received unemployment benefit (section 13 (3)).

BULGARIA

ACT OF 6 MARCH 1924

Qualifying Period

Cash benefit is due to insured persons who have paid their contributions to the Social Insurance Fund for not less than eight consecutive weeks (section 19, subsection 1). If an insured person without valid reason interrupts the payment of his contributions, he must again pay them for eight consecutive weeks before he is entitled to cash benefit (Regulations, section 160, subsection 2).

In seasonal trades it is sufficient for establishing a claim to cash benefit that the insured person shall have belonged to the Social Insurance Fund for not less than eight weeks during the season, unless the seasonal work is of shorter duration owing to its nature (section 19; subsection 2).

Waiting Period

An insured person who has completed his qualifying period may claim sickness benefit from the first day of incapacity to work (section 19, subsection 1).

CHILE

ACT OF 8 SEPTEMBER 1920

Qualifying Period

Insured persons are entitled to benefit after a qualifying period of seven months dating from the first payment (for a disablement pension the qualifying period is two years dating from the first payment) (section 22, subsection 1).

Waiting Period

Sickness benefit is payable from the fifth day of the sickness, but if the sickness lasts for more than a week the insured person may claim benefit from the first day of the incapacity to work (relative waiting period) (section 15 b).

CZECHOSLOVAKIA

ACT OF 9 OCTOBER 1924

Qualifying Period

There is no provision for a qualifying period for compulsorily insured persons. For persons employed irregularly, i.e. persons whose employment is merely temporary owing to its character, or the duration of whose employment with the same employer is fixed in advance by the contract of work at less than a week, and for charwomen, visiting seamstresses, and other persons employed by different employers in turn a qualifying period may be fixed (section 248, subsection 2).

Voluntarily insured persons (who are not continuing a formerly compulsory insurance) are not entitled to benefits until after a period fixed by the rules which must not be less than four or more than eight weeks (section 251, subsection 3).

Waiting Period

Benefit is payable from the fourth day of incapacity. It is not due for Sundays when the incapacity for work lasts less than a fortnight. If it lasts more than a fortnight the benefit is due as from the third day of incapacity. Benefit is payable for the last day of incapacity if this is not a working day (section 95, 1). The waiting period is absolute, being either three or two days according as the incapacity lasts more or less than a fortnight.

Residential Conditions

Sickness benefit may not be refused to insured persons who are outside the area of the fund, but obviously the fund must be able to supervise the sick person in accordance with the provisions of its rules.

Period of Protection

If an insured person has ceased to perform work or render services entailing liability to insurance, and has no earnings and is not in receipt of a pension under the invalidity and old-age insurance system, or other pension, and is resident in the territory of the Czechoslovak Republic, he has a right to sickness insurance benefits if the event giving rise to the claim occurs within a period equal to the last continuous period during which he performed work or rendered services entailing liability to insurance, but in any case within a period of not more than six weeks (section 97, subsection 4). If an unemployed insured person within this period of protection begins to perform work or render services entailing liability to insurance, the period of protection may not be reduced by the period of such work or services (section 97, subsection 5).

ESTHONIA

ACT OF 23 JUNE 1912

Qualifying Period

No qualifying period is prescribed.

Waiting Period

Sickness benefit is payable from the fourth day following the beginning of the sickness, but persons who are insured under the Workers' Accident Insurance Act, and become incapable of work under the conditions specified in that Act, may obtain cash benefit from the day of the accident (section 311). The rules may provide that the sickness benefit shall be paid before the fourth day following the beginning of the sickness (section 380, subsection 2)

Period of Protection

An insured person who leaves his fund retains his right to cash benefit for one month after passing out of insurance unless he has already joined another fund.

FRANCE (Alsace-Lorraine)

SOCIAL INSURANCE CODE OF 19 JULY 1911

Qualifying Period

Compulsorily insured persons acquire the right to ordinary benefits on joining the fund, that is to say, from the date they enter an occupation entailing liability to insurance (sections 206, 306).

The rules may provide that persons not liable to insurance who may join voluntarily shall not be entitled to ordinary benefits until after a specified period, which may not be more than six weeks (section 207).

The rules may also provide that both for compulsorily and for voluntarily insured persons the right to supplementary benefits may not begin until after a period of not more than six months from the date of joining the fund. This provision cannot apply to members who during the last twelve months have already been entitled for not less than six months to supplementary benefits from a mining sickness fund (section 208).

Waiting Period

Sickness benefit is payable from the fourth day following the beginning of the sickness, or if the incapacity does not begin until later, as from the day on which it begins (section 182). In spite of this regulation the rules may allow sickness benefit as from the first day of incapacity for sicknesses lasting over a week, for those which prove fatal, those due to an industrial accident, and other sicknesses. In the latter case the consent of the Superior Social Insurance Office is necessary (section 191).

Residential Conditions

See the similar provisions in the German Social Insurance Code (p. 190).

Period of Protection

See the similar provisions in the German Social Insurance Code (p. 190).

GERMANY

NOTIFICATION OF THE NEW TEXT OF THE FEDERAL INSURANCE CODE OF 15 DECEMBER 1924

Qualifying Period

Compulsorily insured persons obtain the right to ordinary benefits from the date of membership, i.e. of entering an employment entailing liability to insurance (sections 206, 306-308).

For additional benefits the rules may provide that the right to these benefits shall not begin until after a qualifying period of not more than six months from entry into a fund. Such provision must not apply to members who for not less than six months during the last twelve months have had a right to additional benefits from a sickness fund subject to the Code, or the Federal Miners' Benefit Society. In cases of withdrawal from membership, this period may be interrupted for not more than 26 weeks (sections 208 and 209).

For temporary workers the rules may provide that they shall not have a right to benefits during a qualifying period of not more than six weeks. In case of a previous period of membership not more than 26 weeks earlier, the duration of that period is deducted from the qualifying period. If a casual worker during the last 26 weeks before falling sick has failed for more than eight weeks to pay his share of the contribution, he retains only the right to medical attendance. This provision applies also to all insured temporary workers whose membership has not yet lasted for 26 weeks if they have failed for more than a quarter of the period of insurance to pay their share of the contribution (sections 151 and 152).

The rules may provide that for persons who are empowered by the Code to lose voluntarily the right to benefit shall not arise until after a waiting period of not more than six weeks (section 207).

Waiting Period

Sickness benefit is payable from the fourth day following the beginning of the sickness or, if the incapacity does not begin until later, as from the day on which it begins (section 182 (2)).

The rules may provide sickness benefit as from the first day of incapacity for sicknesses lasting over a week, for those which prove fatal, those due to an industrial accident, and other sicknesses. In the latter case the consent of the Superior Social Insurance Office is necessary (section 191, subsection 2).

Residential Conditions

A sick person resident outside the district of his fund may on the demand of his fund be paid the benefits due to him from it by the general local sickness fund for his place of residence. This provision applies to insured persons who leave the fund owing to unemployment (section 219).

An insured person who falls ill during a temporary stay outside the area of his fund receives the benefits to which he is entitled from the general local sickness fund for the place where he is staying, for so long as his condition prevents his return to his place of residence. In this case an application from the competent fund is unnecessary (section 220).

If a claimant voluntarily betakes himself to a foreign country without the consent of the committee of the fund after the occurrence of the event giving rise to the claim, he loses his right to sickness benefit for so long as he remains there without such consent. For certain districts the Federal Government may cancel the suspension of the claim (section 216, subsection 1 (2)). If the claimant has relatives in Germany, they retain any rights they have to family benefits.

If an insured person ceases to reside in Germany after the occurrence of the event giving rise to benefit without suspension of sickness benefit (involuntary stay, or stay with the consent of the committee), the sickness fund may free itself of its obligations towards him by paying him a lump sum in commutation. This sum must be equivalent to the value of the benefits from the fund to which he would have been entitled in Germany in view of the probable duration of the sickness (section 217, subsection 1).

Period of Protection

An insured person who leaves a fund on account of unemployment retains his claim to the ordinary benefits of the fund if the event giving rise to benefit occurs during his unemployment and within three weeks of his leaving, provided that he has been insured for not less than 26 weeks during the preceding 12 months, or for not less than six weeks immediately preceding his leaving. This claim lapses if the unemployed person remains abroad and the rules contain no provision to the contrary (section 214, subsections 1 and 3).

GREAT BRITAIN

ACT OF 7 AUGUST 1924

Qualifying Period

An insured person is not entitled to sickness benefit until 26 weeks have elapsed since his entry or re-entry into insurance and 26 weekly contributions have been paid by or in respect of him. For disablement benefit and for the full rate of sickness benefit the period is fixed at 104 weeks since entry or re-entry into insurance, and 104 weekly contributions must have been paid in respect of the insured person (section 13, subsection 3).

Waiting Period

Sickness benefit is payable on and from the fourth day of the incapacity to work. The first day of incapacity to work is deemed to be that on which the insured person is prevented from engaging in actual work (section 10, subsection 1 (b), and *Approval Societies' Handbook*, 1925, para. 302).

Residential Conditions

In general insured persons cannot claim sickness or disablement benefit while resident outside Great Britain and Northern Ireland, except in the case of a temporary stay in the Irish Free State, or if the consent of the society has been obtained (section 19). The Act provides for reciprocal arrangements with the Irish Free State, and a Treaty to this effect has been concluded (section 20)

Period of Protection

Any compulsorily insured person who ceases to be employed in an occupation rendering him liable to insurance, or any voluntarily insured person who ceases to pay voluntary contributions, may, for a period of twelve months (exclusive of periods of duly notified sickness) after such cessation, claim all the benefits provided under the Act if he becomes incapable of work during such period, without the payment of contributions. At the end of this year he ceases to be insured and cannot again enter into insurance without complying with the general regulations (section 3)

Special provisions were adopted under the Prolongation of Insurance Act, 1921, for the assistance of unemployed persons. If they have proved their unemployment they are kept in insurance. Moreover they are deemed to have paid 26 contributions a year, and are therefore entitled to the minimum benefits in cash and in kind. Further, they may obtain cash benefit at the full rates by paying the prescribed penalty for arrears of contributions.

A deposit contributor is entitled to sickness and disablement benefit, but as benefit is not payable after his deposit is exhausted there is no effective protection in the event of permanent disablement. Persons belonging to the Army and Navy are not entitled to sickness or disablement benefit.

The right of an insured person to sickness benefit and disablement benefit ceases on his attaining the age of 70 (section 30, subsection 8). As from 2 January 1928 this age limit will be reduced to 65 (Widows', Orphans' and Old-Age Contributory Pensions Act, 1925, Fourth Schedule, Part III)

HUNGARY

ACT XIX OF 6 APRIL 1907

Qualifying Period

No qualifying period is required of compulsorily insured persons. They are entitled to claim sickness benefit from the day they enter employment regardless of whether they have satisfied the formalities laid down in the Act or not.

Voluntarily insured persons acquire the right to sickness benefit from the day on which the fund admits them to membership.

Waiting Period

Sickness benefit is granted for incapacity lasting more than three days as from the third day (Orders 4,790 of 1917 and 5,400 of 1919 abolishing the relative waiting period fixed under the 1907 Act)

Residential Conditions

If a compulsorily insured person is not in Hungary when he falls ill, the employer must pay him the benefit to which he is entitled, but may require the National Workers' Insurance Fund to refund any payments so made (section 66, subsections 1 and 2).

Period of Protection

Any person who has been insured for not less than six consecutive months in the course of a year, but owing to unemployment is unable to continue the payment of his contributions, is entitled to the statutory minimum sickness benefit for three weeks after leaving the fund, on condition that he remains in the country. If he was insured for not less than twelve consecutive months within a period of two years, he is entitled to such continued benefit for six weeks (section 61, subsection 1).

IRISH FREE STATE

ACT OF 16 DECEMBER 1911

The provisions regarding qualifying period (section 8, subsection 8), waiting period (section 8, subsection 1 (c) as amended), and residential conditions, *mutatis mutandis*, are the same as those in force in Great Britain. With regard to the period of protection, the free year's insurance is granted in the same way as in Great Britain (Act of 6 February 1918, section 13, subsection 1) and the Prolongation of Insurance Act, 1921, is also in force in the Free State, the reduction of the age limit from 70 to 65, however, applies only to Great Britain.

ITALY (New Provinces)

ACT OF 29 NOVEMBER 1925, No. 2,416

Waiting Period

Sickness benefit is payable from the fifth day after the insured person has notified his sickness (section 9).

JAPAN

ACT OF 22 APRIL 1922

Qualifying Period

The right to benefit appears not to be subject to a qualifying period or the minimum payment of contributions.

Waiting Period

In case of sickness or injury through any cause unconnected with the work, benefit is payable from the fourth day of incapacity to work (section 45).

LATVIA

The legal provisions resemble those in force in Esthonia (see page 188).

LITHUANIA

ACT OF 23 JUNE 1912

Qualifying Period

The law contains no binding provision for a qualifying period, but any fund may provide in its rules that sickness benefit shall be paid only to members who have belonged to the fund for a specified period (section 51).

Waiting Period

Sickness benefit is granted from the fourth day of sickness.

LUXEMBURG

SOCIAL INSURANCE CODE OF 17 DECEMBER 1925

Qualifying Period

To be able to claim sickness benefit a compulsorily or voluntarily insured person must have belonged to a fund for at least eight days before the sickness began. As an exception, the claim exists as from the date of joining the fund in cases of occupational accidents involving incapacity to work for a fortnight (section 16, subsection 2).

Further, the rules of the fund may lay down that both compulsorily and voluntarily insured persons must have belonged to the fund for a specified period not exceeding six months before they obtain the right to additional benefits. Such a provision cannot apply to members who during the last 12 months have already been entitled, for at least six months, to additional benefits from another fund. This qualifying period with respect to additional benefits is not suspended by an interruption of membership not exceeding 26 weeks (section 12, subsections 3 (b) and 4).

For voluntarily insured persons the rules may provide a qualifying period of not more than six weeks (section 16, subsection 3 (a)).

Waiting Period

Sickness benefit is granted for each working day from the third day following the beginning of the sickness, or, if the incapacity to work does not occur until later, from the day on which it occurs (section 8, subsection 1 (2)).

Residential Conditions

A sick person resident outside the district of his fund is paid, on the demand of his fund, the benefits due to him by the local fund of his place of residence. The same provision applies to insured persons who leave the fund owing to unemployment (section 22, subsections 1 and 2).

Similarly, insured persons who fall sick during a temporary stay outside the district of their fund receive benefit from the local fund for the place where they are staying, for so long as their state of health prevents them from returning home, no application on the part of their fund being necessary (section 22, subsection 3).

If an insured person ceases to reside in Luxemburg (goes abroad with the consent of the committee of the fund) after the occurrence of an event giving him a claim to insurance benefits, the fund may arrange, in accordance with the provisions of its rules, for the payment to him of a lump sum to be fixed in accordance with the regulations laid down by the Central Committee. This payment frees the fund from all its obligations to the insured person (section 23, subsections 1 and 2).

In the case of insured persons or other claimants who voluntarily go abroad without the consent of the executive committee of their fund, their sickness benefit is suspended for so long as they stay abroad without such consent (section 21, subsection 1 (2)).

Period of Protection

If an insured person who leaves the fund on account of involuntary unemployment has been insured for at least 26 weeks during the preceding 12 months, or for not less than ten weeks immediately preceding his leaving, he retains a claim to the regular benefits from the fund if the sickness occurs during his unemployment and within three weeks of his leaving. This claim lapses, however, if he lives abroad and the rules contain no provision to the contrary (section 20).

NORWAY

ACT OF 6 AUGUST 1915

Qualifying Period

No qualifying period is fixed for compulsorily insured persons.

Waiting Period

Sickness benefit is payable in respect of all weekdays, but not for the first three days (including Sundays) from the beginning of the incapacity to work (section 19, subsection 1).

Residential Conditions

If a member of a district fund falls ill while staying in the area of another district fund, the latter makes the necessary provision for the payment of benefits and the treatment of the sick person (section 28 subsection 1).

If a person, while abroad, acquires a claim to benefit, his employer is bound, for so long as he remains abroad, to pay for the benefit which he would otherwise have received from the district sickness fund (section 23). It should be added that, according to section 3 of the Act, a compulsorily insured person who leaves the country is considered to be still employed in Norway for a period of three months after going abroad if he is temporarily employed by his employer in another country, or if, with the permission of his employer, he goes on a journey abroad for that period.

POLAND

ACT OF 19 MAY 1920

Qualifying Period

Compulsorily insured persons, except home workers and temporary workers, are entitled to benefits from the day on which they enter an occupation entailing the liability to insurance (section 35, subsection 1).

Home workers, temporary workers, and voluntarily insured persons acquire the right to benefits after not less than four and not more than six weeks' membership of the fund, but voluntarily insured persons are not entitled to benefit in respect of a sickness from which they were already suffering at the time of joining the fund. If a home worker or a temporary worker has been a member of a fund on a former occasion for not less than 26 weeks, the new membership is considered as a continuation of the old (section 35, subsections 2 and 3).

Although there is no qualifying period for compulsorily insured persons, except home workers and temporary workers, with respect to the payment of statutory benefits, any extension or increase of benefits as provided in section 26 of the Act — increase of cash benefit by 5 per cent for each child in the case of insured persons with more than two children dependent upon them, subject to a maximum limit of 75 per cent. of the basic wage — may be made conditional upon the length of time during which the insured person has belonged to the fund (section 26, subsection 2).

Waiting Period

The cash benefit is payable in respect of each day's incapacity for work from the third day of incapacity, including Sundays and holidays (section 23, subsection 1 (b)).

Residential Conditions

Temporary residence outside the district of the fund does not entail the loss of the right to benefits, which are then paid by the fund of the place of residence at the expense of the fund to which the insured person belongs.

The latter is not required to repay the expenses of assistance granted within the limits fixed by the rules unless the fund which paid them notified the sickness within one week (section 37, subsection 1). If an insured person goes abroad during his sickness without the consent of the managing committee, sickness benefit is suspended for the whole period of his stay abroad (section 38 (a)).

Period of Protection

Members of the fund who, owing to unemployment, are unable to pay their contributions, retain the right to medical benefit (but not to sickness benefit) for not more than 26 weeks, provided that the sickness occurs within 13 weeks from the date of their leaving the fund (section 36, subsection 1).

Members of the fund who leave their employment, having belonged to the fund for at least the last six weeks or for 26 weeks during the last 12 months, retain the right to full benefits (including cash benefit) during a period fixed

by the rules of the fund, provided that the sickness occurs within four weeks of their leaving their employment (section 36, subsection 2).

PORTUGAL

DECREE OF 10 MAY 1919, No 5,636

Qualifying Period

An insured person acquires the right to sickness benefit six months after the payment of his first contribution, provided that he is not in arrears with his contributions (section 30 (1))

Waiting Period

No waiting period is fixed for insured persons who have completed their probationary period

Residential Conditions

An insured person living outside the area of the competent mutual aid fund receives the benefit to which he is entitled from the mutual aid fund in the area where he is staying. The payments are made at the expense of the competent fund (section 34)

ROUMANIA

ACT OF 25 JANUARY 1912

Qualifying Period

The 1912 Act in force in the former Kingdom fixes a qualifying period of six weeks for acquiring the right to sickness benefit (section 116).

Waiting Period

Sickness benefit is payable to an insured person who has completed his probationary period, in the event of a loss of working capacity lasting more than three days. If the incapacity lasts more than eight days, the sickness benefit becomes payable for the first three days as well (relative waiting period).

RUSSIA

LABOUR CODE OF 15 NOVEMBER 1922

Qualifying Period

An insured person acquires the right to benefit on the day he enters his employment.

Waiting Period

There is no waiting period properly so called, but benefit is not granted in cases of treatment at home or by consultation, unless the medical certificate states the need of leave. The doctor in charge of the case may give only a few days' leave at a time (5 to 10 days as there is or is not a local medical consultation service). Sick leave for a longer period must be granted by the medical consultation service of the insurance fund, consisting of the doctor treating the case and the medical referee; in case of difference between the two, the medical supervisory committee decides.

Residential Conditions

If an insured person falls ill outside the area of the competent fund, the fund for the district in which he is staying provides for him, it being sufficient that he should submit a certificate proving his ordinary occupation.

SERB-CROAT-SLOVENE KINGDOM

ACT OF 14 MAY 1922

Qualifying Period

Membership, and the consequent right to sickness benefit, dates from the day on which the member enters the employment rendering him liable to insurance, even in the absence of the necessary notification (section 55, subsection 1).

Waiting Period

Sickness benefit is payable if the sickness entails incapacity for work lasting more than three days as from the date on which the sickness or incapacity for work began (relative waiting period) (section 45 (3)).

Residential Conditions

If a member is outside the territory of the Kingdom at the time when he falls ill, the employer must pay him the benefit due to him under the Act, but may claim the repayment from the insurance institution of the legal benefit which he has actually paid (section 61, subsections 1 and 3)

Period of Protection

Any person who has been insured for not less than six months, and is unable to pay his contributions owing to unemployment, is entitled to the minimum sickness benefit for three weeks after leaving the undertaking in which he is employed, provided that he remains within the territory of the Kingdom. If he has been insured for not less than 12 months during two years, he is entitled to benefits for six weeks after leaving the undertaking (section 56, subsection 1).

SWITZERLAND

Appenzell, Inner Rhodes

ORDER OF 29 NOVEMBER 1920

The qualifying period usually fixed is a fortnight, but insured persons who have already been members of other sickness funds are entitled to benefits from the date of joining.

Sickness benefit is payable from the second day following the day on which the sickness begins (section 14)

Appenzell, Outer Rhodes

ACT OF 30 APRIL 1916

For compulsorily insured persons no qualifying period is fixed, but for voluntarily insured persons there is a qualifying period of not more than three months (section 32).

Cash benefit is payable from the third day following the beginning of the sickness (section 33)

St. Gall

ACTS OF 28 MAY 1914 AND 28 NOVEMBER 1919

Insured persons must undergo a qualifying period of a fortnight, unless they are entitled to a free transfer, in which case their right to benefit commences when they join the fund.

Sickness benefit is payable on the third day following the beginning of the sickness (section 37).

CHAPTER II

AMOUNT AND DURATION OF BENEFIT

An insured person who satisfies the conditions established by law and the rules of the insurance institution may claim sickness benefit. This is a legal right, and the institution from which the benefit is due cannot refuse it for other reasons than those accepted by the law or the rules. In this respect all the insured are on an equal footing, and protected against arbitrary decisions by the insurance institution.

The rates of benefit are determined by the law, and no institution may grant less than those rates. The methods of calculating the benefit may vary from one system of insurance to another, or even within any one system, but in any case the insured person is certain of obtaining the minimum benefit prescribed by the law.

On the other hand, he is entitled to the benefit only for so long as he continues to satisfy the conditions laid down, and then only for a certain period. The period of benefit is fixed by the law. The legal period during which a sick person may claim benefit is not the same in all insurance systems, and sometimes differs for different classes of insured persons.

Sickness benefit is intended to compensate, at least in part, for the economic loss sustained by an insured person owing to the suspension of his work. If his state of health so requires, he may or must be treated in hospital at the cost of the insurance system. While in hospital, his treatment and maintenance are provided for, so that cash benefit may be suspended or reduced without any injury to him. In this case, instead of benefit, he receives alternative benefit (*prestation de remplacement, Ersatzleistung*).

Further, the benefit is or may be reduced either because his needs are considered less (for instance, when the insured person continues to receive all or part of his pay, or obtains an allowance under another insurance system in respect of the same sickness) or because his liability towards the insurance institution is too great (for instance, in the case of an offence injuring the institution) for it to be reasonable to require it to pay the ordinary benefit.

If the insurance institution manages its reserves judiciously, it may, under certain conditions, be empowered to grant its members special advantages or additional benefits. Additional sickness

benefit may consist in an increase of the amount, or an extension of the duration of the ordinary benefit, or both, or complete or partial exemption from the waiting period, or all these privileges at once.

These various aspects of sickness benefit will be considered in turn below: rates of benefit, period of benefit, alternative benefits, reduction of benefit, additional sickness benefit; the survey being completed by a summary of national laws and statistics of their administration.

§ 1. — Rates of Benefit

The problem from the legislative standpoint, in fixing the rates of legal benefit is to determine what the economic purpose of such benefits is to be. An insured person who is compelled by sickness to stop work usually suffers an economic loss, which will differ according to the remuneration for the work or services he could not perform owing to sickness. It is understood that the benefit is not intended to make up for the whole loss, and is never more than the earnings lost. But, subject to this restriction, the question is what assistance is to be given to the insured person in the form of legal benefit.

The laws of the different countries adopt one of two conceptions of the part to be played by legal benefit.

The most widely adopted view is that the sick person should be able to retain his social status, and involves the concession of a minimum benefit corresponding to his ordinary standard of life. Among wage-earners this standard is normally determined by the rate of wages or remuneration. If the benefit is to prevent the sick person from falling in social status, it must be fixed with reference to his ordinary earnings. Where the rate of benefit varies with ordinary earnings, its value to all insured persons is the same, irrespective of their economic status.

According to the second conception, the function of sickness benefit is more modest. All that is required of it is that it should offer the insured person the essentials for maintaining a strict minimum of subsistence during periods of inactivity. It is fixed at a flat rate, irrespective of the earnings and standard of life of the insured.

BENEFIT AT FLAT RATES

From the point of view of the management of the insurance institution, benefit at flat rates offers several facilities. Once the claim of the applicant has been established, the benefit can be paid

without any process of adjustment to the particular circumstances. Flat rates of benefit must not be fixed too close to the lower rates of wages, but, if reduced to the strict minimum, they are apt to be of small real value to the better-paid members.

Legal benefit is payable at a flat rate to all insured persons, irrespective of their earnings, under the systems in force in Great Britain (including Northern Ireland) and the Irish Free State. The rate differs according to sex, being 15s. a week for men and 12s. a week for women. In cases of disablement lasting more than 26 weeks, this benefit is replaced by disablement benefit at the rate of 7s. 6d. per week, irrespective of sex. No benefit is payable to insured persons of over 70 years of age (as from 1928, 65 years), when an old-age pension may be claimed. The lower rate of sickness benefit for women corresponds to their lower rate of contributions. It was possible to contemplate and maintain a flat rate for all insured persons of the same sex in countries like Great Britain and Ireland, where the habit of providing for the future and insuring is deeply rooted, and it is easy to insure against any risk. In this case the legal benefit covers only the primary, most urgent need for insurance, each member being free, according to his own wishes and powers, to cover the risk more fully elsewhere. As a matter of fact, insured persons whose wages leave them a certain margin very largely insure with another institution as well, working without active State support, so that if occasion arises they obtain benefits in addition to the minimum benefit under compulsory insurance.

A flat rate of benefit is also to be found in the laws of several Swiss Cantons. The daily rate is fixed at 3 francs in the Canton of Appenzell (Inner Rhodes) for citizens of the Canton and insured persons resident in the Canton who hold a permit of residence, and at 1 franc for persons staying in the Canton, and at not less than 1 franc in the Cantons of Appenzell (Outer Rhodes) and St. Gall. This sickness benefit is primarily intended to cover the costs of the necessary treatment at home or in a hospital.

BENEFIT AT VARIABLE RATES

In all other compulsory sickness insurance systems the rate of benefit is variable, being determined in principle by the ordinary earnings of the insured person when he falls ill. A variable rate has the advantage over a flat rate of affording the recipient assistance in keeping with his resources and standard of living. On the other hand, it means that the insurance institution must always know

what the wage is which is to be taken as the base for calculating the sickness benefit (basic wage).

The nearer the basic wage is to actual earnings, the closer the sickness benefit will be to the ordinary resources of the sick person. However desirable it may be to maintain a definite proportion between the rates of sickness benefit and of earnings, the difficulties involved in recording the individual wages of each insured person often necessitate giving up that system. The basic wage is therefore fixed not in an exact, but only in an approximate, ratio to earnings. This approximation is obtained by establishing wage classes or categories of insured persons. Reference may be made to the detailed account of the mechanism of wage classes and the advantages and limitations of the system given in another Chapter¹. It need merely be stated here that the difference between actual earnings and the basic wage may be considerable, and that every such system fixes a maximum basic wage above which actual earnings are no longer taken into account.

The legal benefit is fixed at a specified proportion of the insured person's basic wage, and represents a varying proportion of his ordinary earnings. The closer the basic wage is to actual earnings the more fully will the variable rate of benefit cover his needs. The proportion of the basic wage granted as sickness benefit varies considerably from country to country. This will appear from the following table.

RATE OF BENEFIT EXPRESSED AS A PERCENTAGE OF THE BASIC WAGE

Country	Per cent of basic wage
Austria	66 $\frac{2}{3}$ –80
Czechoslovakia	about 66 $\frac{2}{3}$
Esthonia	50–66 $\frac{2}{3}$
France (Alsace-Lorraine)	50
Germany	50
Hungary	60–75
Italy (new provinces)	50
Japan	60
Latvia	66 $\frac{2}{3}$ –100
Lithuania	50–100
Luxemburg	50
Norway	60
Poland	60
Roumania, former Kingdom	50
Ardeal and Bukovina	60
Russia	100 ¹
Serb-Croat-Slovene Kingdom	about 66 $\frac{2}{3}$

¹ If their resources are inadequate, the central institutions may temporarily reduce the rate of benefit for temporary incapacity, but not to less than 75 per cent of the basic wage.

¹ See Part III, Chapter I.

Under this system the legal benefit is in proportion to wages, but no allowance is made for individual differences. This is effected, at least to a certain extent, by the additional benefit or special relief which the insurance institution may grant¹. In certain laws, however, the legal rate of benefit itself is made flexible and varies with the particular needs of each group of insured persons, and the percentage of the basic wage granted in benefit is fixed differently for certain groups. It may be increased or reduced, according to circumstances, for sick persons whose incapacity is persistent, for low-paid workers or, on the contrary, for better-paid workers. Finally, different rates may be fixed for persons with family responsibilities and those without.

Prolonged Sickness

Certain laws increase the legal rate of benefit if the incapacity is prolonged beyond a fixed period. Thus, under the Hungarian Act the sickness benefit, which during the first four weeks of sickness is calculated at 60 per cent. of the basic wage, is raised as from the fifth week of incapacity to 75 per cent. Under the Chilean and Portuguese Acts, on the contrary, the rate of benefit decreases with the duration of the incapacity, in Chile week by week and in Portugal month by month.

Insured Persons with Low Wages

The rate of benefit may be increased for insured persons with low wages or decreased for the more highly paid. Thus, in Austria, it is 80 per cent. of the basic wage for the first seven wage classes, 74 per cent. for the eighth class, and only 66²/₃ per cent. for the ninth and tenth classes.

Family Responsibilities

Family responsibilities may be taken into account by granting family allowances in addition to the benefit. The insurance institutions of several countries have long taken advantage of their power to make an allowance for family responsibilities by granting additional benefits, but some laws effect this in the legal benefit itself. Thus, the Roumanian Act reduces the sickness benefit, which is 50 per cent. for the heads of families, to 35 per cent. of the basic wage for sick persons without family responsibilities. Similarly

¹ See below: § 5, p. 208 (Additional Sickness Benefits)

in Chile, a single person with no family responsibilities receives benefit at only half the ordinary rate. In Esthonia, Latvia, and Lithuania the rate of sickness benefit must be fixed within the limits determined by the law, account being taken of family responsibilities. The new German Act on miners' insurance introduces family allowances in addition to the legal benefit, fixing them at 10 per cent. of the basic benefit, while prescribing that the total benefit may not exceed the basic wage. The Bulgarian Act, which similarly grants a family allowance in addition to the basic benefit, fixes it without reference to wages at a flat rate of one leva a day in respect of each child maintained by the insured person.

There are, moreover, considerable differences to be observed between the different systems of fixing the rate of benefit, according as benefit is payable for each day of incapacity or only for working days. The first method is adopted, for instance, in Austria, Germany, Great Britain, Hungary, Poland, Portugal, and the Serb-Croat-Slovene Kingdom; whereas in Bulgaria, Esthonia, Latvia, Luxemburg, and Norway, for instance, benefit is payable only for working days. The Czechoslovak Act adopts a compromise, granting benefit for holidays as well as working days, provided that the incapacity lasts longer than a fortnight.

In conclusion, it may be added that in several countries certain groups of apprentices are not entitled to sickness benefit. This applies to unpaid apprentices in France (Alsace-Lorraine), Germany, Latvia, Luxemburg, Norway, and Poland, and to apprentices not paid in cash in Great Britain and the Irish Free State. In certain other countries, on the contrary, like Czechoslovakia and the Serb-Croat-Slovene Kingdom, unpaid apprentices belong to the lowest wage class and are entitled to the corresponding benefit. In Austria, where the Industrial Code provides that all apprentices who have completed the first third of their period of apprenticeship must be given a minimum remuneration, apprentices belong, during the first year of apprenticeship, to the lowest wage class, rising into the next class at the beginning of the second, and again at the beginning of the third year of apprenticeship.

§ 2. -- Duration of Benefit

Sickness benefit is intended for insured persons who are temporarily unable to work. Their claim to benefit lasts as long as the incapacity, within the limits of a period fixed by the law.

The main consideration in determining the length of the period is that the large majority of insured persons who fall ill should obtain benefit until their recovery. Once the period—which varies from country to country, usually between 26 and 52 weeks, whether consecutive or not—has been passed, the sickness benefit is withdrawn. In that case, however, it is replaced, in a steadily growing number of industrial countries, by an invalidity pension, which is temporary or permanent according to the circumstances.

The maximum period during which sickness benefit is payable is fixed as follows in the different countries:

Country	Maximum period
Austria	52 weeks (26 weeks if the contributor has been a member for less than 30 weeks)
Bulgaria	9 months
Czechoslovakia	52 weeks
Estonia	26 weeks
France (Alsace-Lorraine).	26 weeks
Germany	26 weeks
Great Britain	26 weeks
Hungary.	One year
Irish Free State	26 weeks
Italy (new provinces)	26 weeks
Japan	180 days (during the course of one year)
Latvia	26 weeks
Lithuania	26 weeks
Luxemburg	26 weeks
Norway	26 weeks (in certain cases 39 weeks)
Poland	39 weeks (in certain cases 26 weeks)
Portugal	One year
Roumania· former Kingdom	16 weeks
Ardeal and Bukovina	26 weeks
Serb-Croat-Slovene Kingdom	26 weeks
Switzerland (Appenzell (Outer Rhodes and Inner Rhodes) and St. Gall)	180 days (during a period of 360 consecutive days)

The Chilean Act and the Russian Labour Code fix no maximum benefit for temporary incapacity being paid until the sick person is again able to earn his living or receives a disablement pension.

Moreover, the legal maximum is not the same in every case. It may vary with the period of membership of the insured person, with the age and therefore the financial stability of the fund, or with the nature of the sickness.

The period of membership is taken into account in Austria, where the normal maximum of 52 weeks applies to sick persons who have belonged to a fund for not less than thirty weeks preceding the beginning of the sickness. Other insured persons can claim benefit for only 26 weeks.

The age of the insurance institution is taken into account in Poland, where only the funds which have been in existence for not less than three years have a maximum period of 39 weeks, the maximum for more recent funds being reduced to only 26 weeks.

The nature of the sickness affects the legal maximum in Norway, the period being raised from 26 to 39 weeks in cases of tuberculosis or cancer.

The varying length of time during which sickness benefit can be granted is not by itself a safe criterion for judging the value of any one insurance system as compared with others. In point of fact, the legal maximum period may be extended by the rules of the fund as a form of additional benefit provided for under the law. Moreover, better results may sometimes be achieved by paying benefits at high rates for a short period than by paying benefits at low rates for longer periods. Finally, it should be remembered that the position of a sick person who is incapable of working when he has exhausted his benefit differs considerably according as he can claim a pension or must resort, in the absence of other resources, to public relief or charity. The fact remains, however, that in countries without a pension insurance system covering large sections of the population, the legal period of sickness benefit is an important factor.

§ 3. — Alternative Benefits

The object which the payment of sickness benefit is intended to achieve may be effected in other ways, for instance, by the payment of benefits in kind. Sickness benefit enables the insured person to satisfy at least the prime necessities of life. If the sickness insurance provides him with his maintenance in kind, it no longer needs to pay him benefit in cash.

The large majority of laws empower the insurance institutions to substitute treatment and maintenance in a hospital for the sickness benefit and medical assistance usually given in the doctor's consulting room, or, in case of need, at the home of the sick person.

So far as possible the insurance institutions are even bound to provide for hospital treatment in cases of contagious diseases, or diseases necessitating care which can be given only in a hospital.

As the maintenance of a person treated in hospital is secured, the institution which pays his fees is exempt from the payment of sickness benefit. This is the general rule, adopted for instance in Austria, France (Alsace-Lorraine), Germany, Italy (new provinces), Lithuania, Luxemburg, Norway, Poland, the Serb-Croat-Slovene Kingdom, and, in certain cases, Czechoslovakia.

The situation is somewhat different if hospital treatment is not granted as insurance benefit, or the costs are not met by the insurance institution.

In Bulgaria, an insured person in receipt of hospital treatment retains his right to the legal benefit reduced by one-quarter. In Great Britain, where since 1924 no kind of hospital treatment has been granted under the sickness and disablement insurance system, a sick person in a hospital or convalescent home supported by the State or some other public body, or by private charity, is not entitled to receive benefit himself, but the insurance institution may use his benefit to pay his rent and other expenses, or to cover his hospital fees unless these are met by a public body, and it must pay over any surplus to the insured person when he leaves the hospital. In Japan, an insured person in hospital is entitled to benefit at one-third the normal rate. In Poland and Roumania (former Kingdom) a sick person in receipt of hospital treatment who has no family responsibilities receives a daily benefit of 10 per cent. of his basic wage. Provision for similar benefit is made in Germany, but in this case it is optional¹.

If a sick person treated in hospital has family responsibilities, the suspension of his cash benefit during such treatment might endanger the maintenance of the members of his family, who until then lived with him and were mainly or entirely supported by him. For the protection of the family practically all laws provide for the payment of a special benefit towards its maintenance during the whole period of hospital treatment.

This benefit is fixed, irrespective of the number of persons in the family, at three-quarters of the legal benefit in Bulgaria, and half the normal rate of benefit in Austria, Czechoslovakia, France (Alsace-Lorraine), Germany, Hungary, Italy (new provinces),

¹ See p. 223

Luxemburg, Poland, Roumania, and the Serb-Croat-Slovene Kingdom ¹.

In certain other countries the rate of benefit depends on the size of the family maintained by the insured person. In Japan it is fixed at 40 per cent. of the basic wage if he has two dependants, and 60 per cent. if he has three or more. In Norway it is 35 per cent. of the daily wage if there are two persons in the family, and 50 per cent. if there are three or more.

Finally, in Great Britain, the benefit due to a person treated in hospital may be granted to his family.

§ 4. — Reduction of Benefit

A sick person who satisfies the conditions for obtaining benefit is entitled to it at the full rate appropriate in his case, and the insurance institution may reduce the rate only for the reasons admitted by the law. It has already been pointed out that in general the sickness benefit may not exceed the wages lost owing to sickness. A varying proportion of the loss must be met by the insured person himself. In other words, it must still be to his interest to maintain himself and to return to productive activity. The difference between the ordinary earnings and the sickness benefit may be met, however, if he still receives a proportion of his wages in the form of sick pay, or obtains payments from some other insurance system than the statutory system. In order to prevent this plurality of claims, the insurance laws provide for or authorise a reduction of the legal benefit.

Another cause of reduction may lie in the actions or omissions of the insured person if he wilfully induces a sickness, injury, or infirmity. If in cases of this kind the institution is not altogether freed from its obligation to pay benefit, it should at least enjoy partial exemption.

COINCIDENT RIGHTS TO BENEFIT

To prevent a coincidence of rights to benefit, it is provided under many of the insurance systems that the benefit shall be so far reduced that when it is added to the sick pay received by the

¹ See, however, p. 251

insured person or the cash benefit he obtains in respect of the same sickness from another insurance, it does not exceed his average daily wage or the legal rate of benefit, as the case may be.

The reduction may be automatic when the insured person at the same time receives sickness benefit from another insurance (for instance, in Germany), or sick pay (for instance, in Japan). Or else it may be provided by way of the rules of the insurance institution, as in Austria, Czechoslovakia, and Luxemburg, for cases of another insurance, and in Austria and Czechoslovakia for cases of sick pay.

WILFULLY-INDUCED SICKNESS

In cases of sickness wilfully induced by the insured person the insurance institution may be empowered by law to reduce or suspend the benefit for a fixed period: in Bulgaria, for instance, when the person interrupts his treatment, induces sickness by drunkenness or other vice, injures the insurance institution by an offence involving the loss of civil rights, or has recourse to fraud; in Poland, when an insured person who ought to be treated in a hospital for a contagious disease refuses such treatment.

A reduction of the benefit may be provided by the rules of the insurance institution, for instance, in Austria, Bulgaria, France (Alsace-Lorraine), Germany, Hungary, Luxemburg, Poland, and the Serb-Croat-Slovene Kingdom, for one or more of the following reasons: injury to the insurance institution by an offence entailing the loss of civil rights; wilful causation of the sickness; guilty participation in or provocation of brawls and quarrels; injury or sickness due to drunkenness; malingering; delaying recovery by refusing to comply with medical instructions; unjustified refusal to accept hospital treatment, etc.

In Great Britain and Ireland the law introduces yet another reason for reducing benefit or even suspending it altogether, namely, arrears in the payment of contributions. If in the case of a person compulsorily insured less than 48 weekly contributions are paid by or on behalf of him during the year, the benefit is reduced in proportion to the arrears, 26 weekly contributions being the minimum for maintaining a claim to the lowest rate of benefit¹. There is a different scale of arrears for voluntarily insured persons.

¹ See, for Great Britain, pp 228-229.

§ 5 — Additional Sickness Benefits

Many laws empower those insurance institutions whose normal resources are sufficient for the purpose to grant sickness benefit at more than the legal rate. Institutions which manage their resources carefully are thus able to grant special privileges to their members. Before making use of this power of introducing additional benefits, the insurance institution must first of all prove that its finances are satisfactory. If this is so and the additional benefit is included with ordinary benefits, the sick person usually becomes eligible for such additional benefit. Under certain laws, however, special conditions may be attached to the claim for additional benefit. The institution is not altogether free, however, to determine the nature of the additional benefit. Both this nature and the maximum amount must be fixed in accordance with the law.

CONDITIONS FOR INTRODUCING ADDITIONAL BENEFITS

Additional benefits may be paid only while the finances of the institution continue to be satisfactory. In this respect the British and Irish laws are the most careful. No approved society may introduce additional benefits unless the five-yearly valuation of its assets and liabilities shows a surplus, and the sums needed for the payment of additional benefits must be taken from this duly proved surplus.

Most other laws authorising the payment of additional benefits are satisfied with demanding that such payments shall not make it necessary for the insurance institution to increase its contributions above the maximum fixed by the law. These contributions may not be raised to more than $7\frac{1}{2}$ per cent. of the basic wage in Germany and $6\frac{3}{4}$ per cent. in Luxemburg, except to cover ordinary benefits or if the employers and insured persons on the committee of the institution are agreed to the contrary. In Czechoslovakia, sickness insurance contributions must as a rule not exceed 5 per cent. of the average daily wage, and an increase above this limit may be authorised only as an exception for a specified period, and then only to cover the legal benefits and not additional benefits. In Poland, the sickness fund may increase its benefits if its

income is sufficient to cover the ordinary benefits and if the reserve fund is equal to the average annual expenditure. It is bound to do so as soon as the reserve fund is more than double such expenditure.

CONDITIONS FOR GRANTING ADDITIONAL BENEFITS

As a rule it is sufficient that the insured person should satisfy the conditions for obtaining legal benefits as well as those arising out of the very nature of the additional benefit. For instance, the incapacity for work should last longer than the legal period of benefit if the additional benefit consists of a prolongation of this period.

Some laws, however, lay down or authorise the introduction of special conditions for obtaining such benefits. Thus, as already explained, the British and Irish laws allow the payment of additional benefits only out of the surpluses obtained from the working of the last five-yearly period, and as a rule allow only persons who have belonged to an approved society for at least five years, and thus contributed towards the surplus, to claim additional benefits. Other laws authorise the introduction of a waiting period for the claim to additional benefits, but do not make it compulsory. Thus in France (Alsace-Lorraine), Germany, and Luxemburg the rules may provide that only insured persons who have belonged to the fund for at least six months may claim additional benefits.

FORMS OF ADDITIONAL BENEFIT

Additional sickness benefits, being intended to promote different social ends, may take the form either of a prolongation of the period during which benefit is paid, or an increase of the rate of benefit, or partial or total exemption from the waiting period.

Prolongation of Benefit Period

This allows the insured person to obtain benefit for a longer period. The institution may extend the benefit period to the extreme limit allowed by the law. Thus, in Germany, Luxemburg, and Poland the benefit period may be extended to one year, and in Austria to a year and a half.

Increase of Legal Rate of Benefit

The benefit may be increased above the minimum for all insured persons, as in Austria, Czechoslovakia, France (Alsace-Lorraine), Germany, Great Britain¹, Irish Free State¹, Latvia, Poland, and the Serb-Croat-Slovene Kingdom. In certain cases the increase may apply, solely or more particularly, to insured persons with family responsibilities, for instance, in Austria, France (Alsace-Lorraine), Germany, Great Britain¹, Poland, and the Serb-Croat-Slovene Kingdom. It may be granted to low-paid workers, as in Austria, Czechoslovakia, France (Alsace-Lorraine), and Germany. Finally, the increase may be allowed only in cases of prolonged sickness, or it may take the form of the payment of benefit for Sundays and holidays.

Exemption from Waiting Period

This enables the insured person to obtain sickness benefit either after a shorter waiting period than that fixed by law (partial exemption), or from the first day of incapacity (total exemption). Such exemption is allowed in Austria, France (Alsace-Lorraine), and Germany, and may apply either to all sicknesses or only to serious sickness.

§ 6. — Provisions of National Laws and Statistics

Under this head the principal legislative provisions concerning the rate and period of sickness benefit have been summarised for each country in turn. Each survey is followed wherever possible by summary statistics, based on official documents, of the results of administration.

The analysis of the laws covers the following points: rates of benefit; period of benefit; alternative benefits; reduction of benefit; additional benefits.

The summaries of the results of administration show, in so far as official statistics allow: the number of cases of sickness and of days of benefit; expenditure on sickness benefit, total and per insured person; additional benefits.

¹ Subject to the finances of the insurance institutions being found satisfactory (see p 208)

AUSTRIA

Legislation

ACT OF 30 MARCH 1888, NEW TEXT PROMULGATED BY THE ORDER OF
20 NOVEMBER 1922

Rates of Legal Benefit

The rate of benefit for each of the ten wage classes is fixed in the Act itself (section 6 (2))

The table below shows the wage limits for each class and the corresponding sickness benefit

WAGE LIMITS, AVERAGE DAILY WAGE, AND DAILY RATE OF SICKNESS BENEFIT
IN FORCE SINCE THE AMENDMENT OF 18 MARCH 1925¹

Wage class	Minimum and maximum actual daily wage	Average daily wage	Daily sickness benefit
	Schillings	Schillings	Schillings
1	Up to 0.77	0.72	0.58
2	Over 0.77 up to 1.03	0.90	0.72
3	„ 1.03 „ „ 1.13	1.08	0.86
4	„ 1.13 „ „ 1.39	1.26	1.00
5	„ 1.39 „ „ 1.73	1.56	1.24
6	„ 1.73 „ „ 1.87	1.80	1.44
7	„ 1.87 „ „ 2.40	2.10	1.68
8	„ 2.40 „ „ 3.00	2.70	2.00
9	„ 3.00 „ „ 4.20	3.60	2.40
10	„ 4.20	4.80	2.80

¹ Section 6 (2), section 7, subsection 1.

The scale of sickness benefit is degressive, that is to say, the rate is proportionately higher for the lower wage classes than for the higher wage classes. For the first seven classes it is fixed at 80 per cent. of the average daily wage, for the eighth class it is only 74 per cent., and for the ninth and tenth classes only 66½ per cent. of the average wage (section 6 (2))

Sickness benefit is paid for all days of the week.

It may be observed that in certain cases the Austrian Civil Code establishes the claim to a certain proportion of wages during relatively short periods of incapacity. "Any wage-earner retains his right to wages if after having worked for an employer for not less than 15 days he is prevented during a relatively short period, of not more than eight days, from performing his work owing to sickness or accidental circumstances which he has not himself produced wilfully or by grave negligence. The same provision applies if he is prevented from working for some other important personal reason for which he is not to blame"

The employer is empowered to deduct from the wages due to a person thus prevented from working a proportion of the payments in cash made to the worker by a social insurance institution, this proportion being equal to that in which the employer contributes to the expenses of the institution (Civil Code, section 1154 b). For certain occupations these provisions have been extended by special legislation, namely, for industrial and commercial employees by the Act of 11 May 1926 on the contracts of employment of private employees, for actors by the Act of 13 July 1922, for agricultural workers by that of 26 September 1923, and for domestic servants by that of 26 February 1920. In these special laws, as in the Civil Code, the provisions are not binding and may be set aside by an individual or collective agreement.

Period of Legal Benefit

The insured person is entitled to sickness benefit if the incapacity for work lasts more than three days as from the beginning of such incapacity (first day

of sickness). If the first or last day of sickness is a holiday, it is not taken into account (section 6 (2)).

Sickness benefit is granted for so long as the incapacity lasts or for 26 weeks if it does not end sooner. If the person entitled to benefit has been insured for at least 30 consecutive weeks, however, he is entitled to sickness benefit for not more than 52 weeks (section 6 (2)).

In calculating the period of sickness benefit, any period of sickness before the beginning of the incapacity for work during which only medical benefit was granted is not taken into account. The right to medical benefit continues in any case for so long as the right to cash benefit exists (section 6 a, subsection 2).

In determining the period of sickness benefit, renewed incapacity for work is not considered as a continuation of the sickness unless it occurs within eight weeks after the cash benefit ceased (section 6 a, subsection 3).

As a general rule the day on which the notice of sickness is given is held to be the first day of sickness. No sickness benefit is granted in respect of any period preceding this date by more than two weeks. For periods preceding it by less than two weeks benefit is paid if it can be shown that the insured person was not in a position to give notice in due time, and he proves incontestably that the sickness causing incapacity for work and the need for treatment began at an earlier date (section 6 b).

Alternative Benefits

Instead of sickness benefit, medical treatment, and free medical requisites, the institution may grant free treatment and attention in a hospital. During such treatment the sickness benefit is suspended. If, however, the person who is treated in hospital has dependants whom he has previously supported out of his earnings, the insurance institution must pay at least one-half of the cash benefit during the whole period of his treatment in hospital at the expense of the institution (section 8, subsections 1 and 4).

The rules may provide that for sick insured persons living outside the district of the fund during their sickness the medical benefit may be replaced either in general or under certain conditions by an increase of the cash benefit (section 9 c, subsection 1 (1)).

Persons who are treated at home may be provided with a nurse. In this case the expenses involved may be deducted from the cash benefit, which, however, may not be reduced by more than half (section 9 (7)).

Reduction of Legal Benefit

In certain cases specified by the Act the rules may provide for reductions of, or restrictions on, legal benefit.

Coincident Rights to Benefit

If an insured person may claim from his employer his full wages or salary during sickness, the cash benefit may be withdrawn or reduced while such claim subsists. In this case the contribution of the insured person may be reduced proportionately (section 9 c, subsection 1 (4)).

False Declaration

If an insured person who is already insured against sickness has not informed the fund of this other insurance within three days after the sickness begins, his benefit may be reduced so that together with the benefit derived from the other insurance it does not exceed his cash wages (section 9 c, subsection 1 (3)).

Willfully-Induced Sickness

The rules may provide that any insured person who has brought his sickness upon himself intentionally or by blameworthy participation in fights or brawls, or whose sickness is the direct result of drunkenness, loses all or part of his claim to cash benefit (section 9 c, subsection 1 (2)).

Additional Benefits

The Act empowers the sickness funds to grant benefits in excess of the legal minimum rates under the rules, but not by a simple decision of the committee.

Various types of additional benefit may be distinguished according to the end in view.

(1) Increase in legal rate of benefit. For the first seven wage classes the daily benefit may be raised to the average daily wage and in the other three classes to four-fifths of the average daily wage. If the incapacity for work lasts more than three months, the sick person may further be placed in another class, with a view to increasing his benefit, account being taken of the average wages at the date of such re-classification paid to persons in the same occupation in the district (section 9, 1).

(2) Extension of minimum period of benefit. The rules may increase this period to a year and a half (section 9, 5).

(3) Sickness of less than three days. Sickness benefit may be granted for sicknesses of three days or less (section 9, 2).

Statistics

Number of Cases of Sickness

The percentage rate of sickness is shown in the table below, taken from the official statistics of the Ministry of Social Administration.

NUMBER OF CASES OF SICKNESS PER HUNDRED INSURED PERSONS IN THE GENERAL SICKNESS INSURANCE SYSTEM

Year	Cases of sickness per cent of insured persons	Year	Cases of sickness per cent. of insured persons
1915	33.6	1921	51.55
1916	36.9	1922	52.80
1917	48.7	1923	47.38
1918	60.9	1924	55.78
1919	46.1	1925	60.27
1920	51.29		

Thus, from 1915 to 1918 the number of cases of sickness increased, but after 1919 it fell. The probable reason is that during the war the powers of resistance of the persons employed in industry gradually fell, and that the difficulties of food supplies had an unfavourable effect on public health. Since 1920 the rate of sickness has again risen owing to the difficult position of the labour market.

Number of Days of Sickness

Not only the rate of sickness, but also the number of days of sickness per insured person (morbidity rate) has risen during the last few years, as will appear from the table below.

NUMBER OF DAYS OF SICKNESS FOR WHICH BENEFIT WAS PAID BY THE SICKNESS INSURANCE FUNDS ¹

Year	Number of days of sickness per insured person		
	All insured	Men	Women ²
1919	11.01	10.65	11.70
1920	10.95	9.92	13.07
1921	10.36	9.24	12.82
1922	10.29	9.51	11.74
1923	10.85	9.67	12.97
1924	12.96	11.49	15.55
1925	14.32	12.74	19.01

¹ *Ämliche Nachrichten des Bundesministeriums für soziale Verwaltung.*

² Including confinements.

General statistics on the distribution of sickness by age groups are not available. The 1924 report of the Vienna District Sickness Fund, which refers to an average membership of 186,411, gives the following percentage distribution of cases of sickness by age groups ¹

Age group	Cases of sickness per cent of total
Up to 20 years	23
From 21 to 30 years	30
„ 31 „ 40 „	17
„ 41 „ 50 „	14
„ 51 „ 60 „	9
„ 61 „ 70 „	5
Over 70 years	1
Age unknown	1

Calculation of Basic Wage

The official statistics show the distribution of the insured by wages classes. The figures for 31 December 1924 are given in the table below. At that date, according to the Act of 30 June 1924, the wage classes were as follows ².

Wage class	Actual daily wage	Basic daily wage	Number of insured in the class per thousand
	Kr.	Kr.	
1	Up to 7,680	7,200	84
2	Over 7,680 up to 10,320	9,000	111
3	„ 10,320 „ „ 11,280	10,800	15
4	„ 11,280 „ „ 13,920	12,600	24
5	„ 13,920 „ „ 17,280	15,600	18
6	„ 17,280 „ „ 18,720	18,000	12
7	„ 18,720 „ „ 24,000	21,000	34
8	„ 24,000 „ „ 30,000	27,000	39
9	„ 30,000	36,000	663

Expenditure on Cash Benefit

TOTAL EXPENDITURE AND EXPENDITURE PER INSURED PERSON ON CASH BENEFIT
PAID BY THE SICKNESS FUNDS IN THE GENERAL SYSTEM ³

Year	Total cost of benefits	Total cost of sickness benefit	Cost of cash benefits per insured person	Cost of sickness benefit per insured person
1919	73.5 million paper kronen	44.4 million paper kronen	97 paper kronen	59 paper kronen
1924	63.56 million schillings	32.35 million schillings	50.9 schillings	25.9 schillings
1925	85.79 million schillings	42.73 million schillings	69.6 schillings	34.0 schillings

¹ Bericht der Wiener Bezirkskrankenkasse für das Jahr 1924

² Amtliche Nachrichten des Bundesministeriums für soziale Verwaltung

³ Ibid

BULGARIA**Legislation**

ACT OF 6 MARCH 1924

Rates of Legal Benefit

A sick person who is given medical attendance receives from the first day of sickness a daily cash benefit, the rate of which varies according to the wage class to which he belongs and according as he is treated at home or in hospital.

The following table gives the actual earnings and the daily benefits for each of the five wage classes

RATES OF DAILY WAGES AND SICKNESS BENEFIT ¹

Actual daily wage	Daily sickness benefit	
	in cases of home treatment	in cases of hospital treatment
Levas	Levas	Levas
Up to 15	12	8
Over 15 and up to 30	16	12
„ 30 „ „ „ 45	20	15
„ 45 „ „ „ 60	25	18
„ 60	30	22

¹ Sections 10 and 18, subsection 1, of the Act.

The daily wage is calculated from the stamps affixed to the insurance book during the last 8 weeks, the weekly value of these stamps being added up and divided by 8 (section 166 of the Regulations).

The daily benefit is payable also for Sundays and holidays (section 168, subsection 1, of the Regulations).

In addition to the benefit for home or hospital treatment a bonus of 1 leva a day is granted for each child of the insured person under 16 years of age (section 10, subsection 3, of the Act and section 165, subsection 2, of the Regulations).

Period of Legal Benefit

Benefit is granted for 9 months from the first day of illness. If at the end of this period the insured person has not recovered, the sickness benefit is suspended, and he is granted instead a special benefit equal to 75 times the daily benefit payable in cases of home treatment, i.e. 75 times 12, 16, 20, 25, or 30 levas, according to the wage class of the insured person (section 20 of the Act and section 171, subsection 3, of the Regulations).

Alternative Benefits

It should be observed that in cases of hospital treatment the daily benefit, which is paid at the lower rate, continues to be paid (section 167 of the Regulations). In this case the benefit is paid to the family in return for a receipt signed by the members of the family and countersigned by two witnesses (section 169 of the Regulations).

Reduction of Legal Benefit

The cash benefit may be suspended or withheld for a period fixed by the Governing Body of the Social Insurance Fund.

- (a) if the insured person refuses to submit to treatment or interrupts it;
- (b) if he has incurred the sickness either intentionally or by drunkenness or any other misconduct specified by the Superior Labour and Social Insurance Council;
- (c) if he has caused loss to the social insurance fund by the commission of a crime entailing loss of civil and political rights;
- (d) if it is proved that he is malingering (section 24 of the Act).

Statistics

The data given in the Bulgarian Statistical Year-Book relate to the total expenditure on sickness insurance without separately specifying the expenditure on benefits in cash and in kind

ANNUAL EXPENDITURE ON SICKNESS INSURANCE BENEFITS¹

Year	Expenditure
	(in 1,000 levas)
1919	513
1920	1,016
1921	1,909
1922	3,574
1923	6,968
1924	9,089
1925	25,278

¹ Statistical Year-Book of the Kingdom of Bulgaria.

The heavy increase in expenditure in 1925 is to be ascribed to the coming into operation of the Act of 26 March 1924.

CHILE

Legislation

ACT OF 8 SEPTEMBER 1924

Rates of Legal Benefit

The rate of benefit varies with the duration of incapacity and family responsibilities. An insured person with a family receives his full wage during the first week of sickness, 50 per cent. of the wage during the second week, and 25 per cent. as from the third week. An insured person who is single or has no family responsibilities receives benefit at only half the above rates for the whole period of sickness.

Persons employed in the public services who receive State salaries during their sickness are entitled to a benefit of not more than 25 per cent. of their salaries as from the date on which the payment of their salaries is suspended (section 15 b).

Period of Legal Benefit

Benefit is granted for the whole period of incapacity. An insured person suffering from a chronic disease which leads to total and permanent incapacity for work may claim an invalidity pension on condition that the sickness was not caused wilfully or by a crime or serious offence on his part. This pension is equal to the average income or salary earned during the past year, if he belonged to the fund for at least 10 years, 75 per cent. of that sum if he belonged to it for at least 5 years, and 50 per cent. in other cases. In any case insured persons of over 55 years of age may claim an old-age pension (section 15 e, f).

CZECHOSLOVAKIA

Legislation

ACT OF 9 OCTOBER 1924

Rates of Legal Benefit

The daily sickness benefit granted to an insured person who is incapable of work owing to a sickness not incurred intentionally amounts to about two-thirds of the daily wage.

The following table shows for each of the ten wage classes the actual wage, the basic wage, and the rate of benefit.

CLASSES AND DAILY SICKNESS BENEFIT¹

Wage class	Daily wage	Basic daily wage	Daily sickness benefit
	Kc	Kc.	Kc
1	Up to 6	4	2.70
2	Over 6 and up to 10 . .	8	5.30
3	" 10 " " " 14 . .	12	8
4	" 14 " " " 18 . .	16	10.60
5	" 18 " " " 22 . .	20	13.30
6	" 22 " " " 25.50 .	24	16
7	" 25.50 " " " 28.50 .	27	18
8	" 28.50 " " " 31.50 .	30	20
9	" 31.50 " " " 34.50 .	33	22
10	" 34.50	36	24

¹ Section 12, subsection 1, and section 95, I, 2

In the first wage class the benefit is 67.50 per cent. of the basic wage, in the second to the fourth classes 66.25 per cent., and in the fifth class 66.50 per cent.

The sickness benefit is not due for Sunday when the incapacity for work lasts not more than a fortnight, unless the insured person is paid a weekly (monthly) wage and has performed work or rendered services every day of the week (month). If the incapacity for work lasts more than a fortnight, the insured person is entitled to cash benefit for Sundays as well, that is to say, for every day of the week; and this provision is retroactive, that is to say, the benefit is payable for the first two Sundays as well (section 95. 1, last paragraph).

Period of Legal Benefit

Benefit is payable for not more than a year as from the fourth or third day of incapacity for work. The period during which the insured person is entitled to benefit begins on the fourth (third) day of incapacity and ends one year from the date on which it begins.

If an insured person who has been granted cash benefit is again attacked by the same sickness within not more than eight weeks of the cessation of the payment of the benefit, the latter sickness is deemed to be a continuation of the previous sickness if it entails incapacity for work (section 98)

Alternative Benefits

If the Central Insurance Institution has placed an insured person incapable of work in a private hospital, the sickness insurance institution must pay half the cash benefits to the Central Insurance Institution and the other half to the insured person, for the duration of such treatment but not for more than one year. If the insured person has a family, this right is transferred to its members. In such a case a claim may not be made by any person

other than the person in charge of the household or the members of the family in question who live together. But the members of the family do not receive this benefit if the insured person under treatment is entitled to at least half his wages from this employer (section 148).

It may be added that the members of the family may not claim the benefit if the sick person was placed in a private hospital by the sickness insurance institution and not by the Central Insurance Institution (sections 145 and 146).

Reduction of Legal Benefit

The legal sickness benefit may be reduced in certain cases.

(a) Part or all of the benefit may be refused to insured persons who in case of sickness are entitled to their full wages or free provision in kind (board alone or board and lodging) from their employer. In such case the insurance contribution of these persons is reduced proportionately (section 104 a).

(b) If an insured person is at the same time insured otherwise against sickness or is entitled to receive part or all of his wages even during sickness, and if he fails to notify the insurance institution of this other insurance within three days of falling sick, his benefit may be reduced to such an extent that, together with the benefit received on account of the other insurance or the wages paid to him, it shall not exceed his total money wages (section 104 b).

Additional Benefits

The benefit may be increased under certain conditions up to the following limits, as a form of additional benefit:

(a) The daily benefit may be raised for the first wage class up to Kč 3 60 and in the other classes up to 90 per cent. of the lower limit of the daily earnings for the class (section 105 a).

(b) The benefit may be raised by 10 per cent. of the basic amount if the incapacity for work lasts for more than 13 weeks; by 20 per cent. if it lasts for more than 26 weeks; and by 30 per cent. if it lasts for more than 39 weeks (section 105 b).

(c) The benefit may be raised by not more than 10 per cent. for married insured persons, 20 per cent. for insured persons who have four dependants, and 30 per cent. for insured persons who have a larger family to maintain. For this purpose members of the family are taken to mean only the wife or husband and the children of under 17 years of age (section 105 c). This increase may be granted as from the first day on which the insured person is entitled to sickness benefit.

Additional benefits may not be granted unless the total sickness insurance contribution is not more than 5 per cent. of the average wage, and the insurance institution before introducing the additional benefits has a reserve fund at least equal to the average expenditure for the last three years (sections 105, 159, 178, and 179).

Statistics

Number of Cases of Sickness

The table below gives the number of sick persons and the cases of sickness per 100 insured persons and the number of sick persons per day

NUMBER OF CASES OF SICKNESS AND SICK PERSONS PER 100 MEMBERS AND DAILY NUMBER OF SICK PERSONS IN BOHEMIA, MORAVIA, AND SILESIA

Year	Number of sick persons per 100 insured	Cases of sickness per 100 insured	Daily number of sick persons per 100 insured
1920	41.45	51.81	2.67
1921	47.31	59.99	3.46
1922	51.77	66.49	3.90
1923	45.81	60.27	3.42

Corresponding figures for Slovakia and Sub-Carpathian Russia are not available

Number of Days of Sickness

NUMBER OF DAYS OF BENEFIT AND AVERAGE DURATION OF SICKNESS IN
BOHEMIA, MORAVIA, AND SILESIA

Year	Average number of days of sickness per insured person	Average duration of sickness
1920	9.79	17.57
1921	12.62	19.39
1922	14.22	19.78
1923	12.48	19.18

Expenditure on Sickness Benefit

The average expenditure per member and the proportion of total expenditure incurred in respect of sickness benefit are shown in the two tables below, the first relating to Bohemia, Moravia, and Silesia, and the second to Slovakia and Sub-Carpathian Russia ¹

AVERAGE EXPENDITURE PER MEMBER AND PERCENTAGE EXPENDITURE ON
SICKNESS BENEFIT

(a) *Bohemia, Moravia and Silesia*

Year	Average expenditure ¹	Percentage of total expenditure
	Kc.	
1921	182.15	—
1922	187.88	48.59
1923	140.87	42.08

(b) *Slovakia and Sub-Carpathian Russia*

Year	Average expenditure ¹	Percentage of total expenditure
	Kc.	
1921	98.21	40.20
1922	124.78	40.04
1923	99.38	36.76

¹ Including maternity benefit, and confinement and nursing allowances

ESTHONIA

Legislation

ACT OF 23 JUNE 1912

Rates of Legal Benefit

Benefit in the event of sickness or accident varies between half and two-thirds of the sick person's wages. Within these limits the fund is free to fix the rate of benefit, due account being taken of family responsibilities (section 310, subsection 1).

The rate of cash benefit is fixed once a year by the general meeting of the fund.

The sickness benefit must be calculated for each individual case on the actual earnings of the sick person.

Period of Legal Benefit

Benefit is granted from the fourth day following the beginning of the sickness until the date of recovery, but not for more than 26 weeks, and in the case of a second sickness for not more than 30 weeks in all during the course of one year (section 311).

A person who leaves his fund retains during the month following his departure his right to benefit on condition that he has not already joined another fund (section 279).

Statistics

Number of Cases of Sickness

The following table shows the absolute and relative number of cases of sickness.

NUMBER OF CASES OF SICKNESS FOR WHICH BENEFIT HAS BEEN PAID

Year	Cases of sickness	
	Number	Per cent. of insured
1923	16,731	36.4
1924	15,577	33.4

Number of Days of Sickness

ABSOLUTE AND RELATIVE DAYS OF BENEFIT AND AVERAGE DURATION OF A CASE OF SICKNESS

Year	Days of sickness		
	Total	Per insured	Per case
1923	255,092	5.5	15.2
1924	251,836	5.4	16.2

Expenditure on Cash Benefit

The following table shows the total expenditure on cash benefit and the amount per insured, and separately the total cost of sickness benefit, in Estonian marks. The figures in brackets show the amounts in gold crowns.

Year	Total cost of cash benefits	Total cost of sickness benefits	Cost of cash benefits per insured person
	E. Marks (Gold cr.)	E. Marks (Gold cr.)	E. Marks (Gold cr.)
1923	35,630,000 (386,000)	31,318,000 (339,000)	1,048 (11.3)
1924	35,083,000 (336,000)	30,311,000 (290,000)	1,045 (10)

FRANCE (Alsace-Lorraine)**Legislation****SOCIAL INSURANCE CODE OF 19 JULY 1911***Rates of Legal Benefit*

The rate of benefit is half the basic wage for each working-day (section 182, 2). This basic wage may be calculated in one of three different ways:

- (a) according to wage category;
- (b) according to the class of insured person;
- (c) according to actual earnings.

These various methods of calculation may be adopted in conjunction (section 180).

Period of Legal Benefit

Benefit may be paid up to the end of the twenty-sixth week following the beginning of the sickness, or if cash benefit was granted only from a later date, up to the end of the twenty-sixth week following that date. If during any period only medical attendance is granted, this period is not reckoned in the period of cash benefit, provided that it does not exceed 13 weeks (section 182).

Alternative Benefits

If an insured person who is being treated in hospital has a family which was wholly or mainly dependent on his earnings, the members of the family are granted cash benefit equal to half the sickness benefit, which may be paid to them direct (section 186).

Reduction of Legal Benefit

If an insured person receives at the same time sickness benefit from another system of insurance, the fund must reduce its benefit so that the total he receives may not exceed his average daily wage. The rules of the fund may, however, suspend all or part of this reduction (section 189).

The rules may refuse all or part of the cash benefit to insured persons:

- (1) for one year from the date of the offence if they injure the fund by an action entailing the loss of civil rights;
- (2) for the duration of the sickness if the sickness was induced wilfully or by guilty participation in a brawl or quarrel (section 192, 2).

Additional Benefits

The payment of benefit at rates above the legal rate is permissible under the law. The rules may:

- (1) grant sickness benefit for Sundays and holidays;
- (2) grant sickness benefit as from the first day of incapacity for sicknesses lasting for more than a week, for those which prove fatal, those due to an industrial accident, and, subject to the consent of the Superior Insurance Office, for other sicknesses;
- (3) extend the period of cash benefit to one year;
- (4) raise the cash benefit to three-quarters of the basic wage;
- (5) grant an insured person who is not entitled to a family allowance a special benefit not exceeding the legal minimum (sections 187, 191, and 194).

Statistics

Number of Cases and Days of Sickness

ABSOLUTE AND RELATIVE NUMBER OF CASES OF SICKNESS; AVERAGE NUMBER OF DAYS OF BENEFIT PER CASE AND PER INSURED

Year	Cases of sickness		Number of days of sickness	
	Number (000's)	Per cent of insured	Per sickness	Per insured
1919	169	49	20	9.98
1920	181	47	18	8.30
1921	196	50	20	10.05
1922	239	58	19	10.97
1923	238	54	19	10.50

Total and Average Expenditure on Sickness Benefit

EXPENDITURE ON SICKNESS BENEFIT' TOTAL AND PER INSURED

Year	Total expenditure		Expenditure per insured	
	All benefits (000's frs)	Cash benefit (000's frs)	All benefit (francs)	Cash benefit (francs)
1919	26,543	13,682	77 7	40.0
1920	34,072	15,692	129 5	35.5
1921	52,667	24,618	134 7	62.9
1922	62,750	29,090	151 8	70.4
1923	68,078	29,068	155 0	66.2

It will be remembered that the rules may provide for the grant of various additional benefits, for instance, extension of the period of benefit beyond 26 weeks, increase of sickness benefit up to 75 per cent. of the basic wage, abolition or reduction of the legal waiting period, payment of benefit for Sundays and holidays.

The following table shows the number of funds which in each year granted benefit on more favourable terms than the minimum

FUNDS GRANTING SICKNESS BENEFITS ON MORE FAVOURABLE TERMS THAN THE LAW

Year	Number of funds	Funds granting sickness benefit of		Funds granting benefit from the first day		Funds granting benefit from the second or third day		Funds granting benefit on Sundays and holidays		Funds granting benefit on holidays only	
		50 to 66 per cent of basic wage	66 to 75 per cent of basic wage	in all cases	in certain cases	in all cases	in certain cases	in all cases	in certain cases	in all cases	in certain cases
1919	264	32	3	17	186	68	9	39	4	75	1
1920	257	58	12	15	190	77	9	44	4	85	0
1921	252	67	5	5	188	16	10	42	3	79	0
1922	247	61	5	24	181	74	9	47	4	86	0
1923	247	68	3	24	181	76	10	44	11	89	0

GERMANY

Legislation

NOTIFICATION OF THE NEW TEXT OF THE FEDERAL INSURANCE CODE OF 15 DECEMBER 1924

Rates of Legal Benefit

The cash benefit is equal to half the basic wage for every calendar day (all days of the week) (section 182, 2)

There are three methods of calculating the basic wage, on which the sickness benefit and other cash benefits depend

- (1) According to the actual earnings of each insured person.
- (2) According to wage classes as determined by the rules of the fund. The basic wage then corresponds to the arithmetic mean between the upper and lower limits of the class. The fixing of the wage classes and the basic wage must be submitted to the Superior Insurance Office for approval.
- (3) According to occupational classes of insured persons. The basic wage for a class is the wage fixed for it by collective agreement or, if there is no such wage, the average daily wage. This basic wage must also be approved by the Superior Insurance Office.

The rules of a fund may provide that the various methods of calculating the basic wage shall be used in conjunction. The committee of management may, if the rules fix the basic wage according to wage class or class of insured persons, decide that for certain groups of insured or certain undertakings the actual earnings shall be the basic wage.

In all three methods the basic wage represents earnings for each day in the calendar year. Account must be taken of earnings for each day in the calendar year up to 10 marks. For calculating earnings the week is reckoned as seven days, the month as 30 days, and the year as 360 days (section 180 of the text of the Act, dated 15 July 1927)

Period of Legal Benefit

Sickness benefit ends not later than the end of the twenty-sixth week from the beginning of the sickness or from the day on which benefit was first received if this is later. If a period during which only medical attendance is granted interrupts the period of receipt of cash benefit, the former period up to a maximum of 13 weeks is not included in calculating the period for the receipts of cash benefit (section 183, subsection 1).

The sickness is considered to begin either on the day on which incapacity for work begins or on the day on which a medical practitioner is consulted. If during the course of a sickness so defined a new sickness occurs, this is not considered as a new case of sickness. The sickness is deemed to have come to an end if the insured person no longer needs medical treatment or sickness benefit because he is again capable of working.

Alternative Benefits

Instead of the medical attendance and cash benefit the fund may grant treatment and maintenance at a hospital. If the person treated in hospital has a family until then wholly or mainly supported out of his earnings, the members of the family are granted an allowance equal to half the sickness benefit, which may be paid direct to them (section 186).

Reduction of Legal Benefit

Coincident Rights to Benefit

If an insured person receives cash benefit at the same time in respect of another insurance, the sickness fund must reduce its benefit to such an extent that the total benefit received by the insured person does not exceed the average amount of his daily earnings. This reduction may be wholly or partly suspended by the rules (section 189).

Chronic Diseases

For an insured person who has already received cash benefit or the benefits substituted for it for 26 weeks consecutively or altogether within twelve months either under the federal insurance system or from the Federal Miners' Benefit Society or a substitute fund, sickness benefit may be restricted by the rules to the regular benefits and to a total period of 13 weeks if any new sickness occurs during the next twelve months. This provision does not apply, however, unless the second case of sickness is due to the same cause as the first (section 188).

Treatment at Home

If, with the consent of the insured person, he is given treatment at home the rules may provide that not more than one-quarter of the cash benefit is to be deducted (section 185).

Actions Injuring the Fund

The rules may provide for the refusal of all or part of the sickness benefit for one year from the date of the offence if the insured person injures the fund by an action entailing the loss of civil rights (section 192, 1)

Wilfully-Induced Sickness

The rules may similarly refuse benefit in part or altogether for the duration of the sickness if the sickness was incurred intentionally or by participation in a brawl or quarrel (section 192, 2).

Additional Benefits

Under the Code the sickness funds may grant insured persons who are incapable of work benefits in addition to the legal minimum benefit. According to the social end aimed at by the additional benefit, a distinction may be made between three types of such benefit:

(1) Extension of the minimum period during which benefit is payable. The rules may extend the duration of sickness benefit up to one year (section 187, 1).

(2) Increase of the legal benefit. Increase for all recipients. The cash benefit may be increased by the rules to not more than three-quarters of the basic wage (section 191, subsection 1).

Increase for recipients with family responsibilities. Subject to the consent of the Superior Insurance Office and a maximum limit of three-quarters of the basic wage, the rules may graduate the sickness benefit granted according as the recipient is married or single, and also according to the number of children and other relatives whom the insured person has hitherto maintained wholly or mainly out of his earnings (section 191, subsection 3, 1).

Increase for low-paid insured persons. Subject to the consent of the Superior Insurance Office and the maximum limit of three-quarters of the basic wage, the rules may provide for the granting of bonuses on cash benefit for all wage classes or only for the lower classes, at the same rate for all classes or at a higher rate for the lower classes (section 191, subsection 3, 2).

(3) Exemption from the waiting period. The legal waiting period is three days, so that benefit is payable only from the fourth day of sickness. Nevertheless, the rules may provide for the payment of benefit from the first day of incapacity in case of sickness lasting for more than a week, resulting in death, or due to an industrial accident, and also, with the consent of the Superior Insurance Office, in other cases of sickness (section 191 subsection 2).

Statistics*Number of Cases of Sickness*

There has been a considerable increase in the percentage number of cases of sickness as compared with 1888. In that year the proportion of insured persons who fell sick was 33.5 per cent. for men and 28.8 per cent. for women,

the corresponding figures for 1924 being 46.1 per cent. and 41.7 per cent. Similarly there has been a considerable increase in the proportion of sick persons to actively insured members, especially during the last few years. Thus the Central Federation of Sickness Funds, which includes 986 funds with an average aggregate membership of 8,692,934, reports that on 1 January 1924, 1.95 per cent. of all the insured applied for sickness benefit, on 1 January 1925 3.67 per cent., and on 1 January 1926 5.8 per cent.

NUMBER OF CASES OF SICKNESS IN FUNDS SUBJECT TO THE FEDERAL INSURANCE CODE ¹

Year	Cases of sickness (in thousands)	Cases of sickness per 100 insured		
		All insured	Men	Women
1913	—	42.1	44.1	37.5
1922	8,750	47.7	47.9	47.2
1923	6,171	34.1	34.2	33.9
1924	7,466	43.2	45.5	39.4
1925	9,398	51.5	54.8	46.0

¹ Figures for 1914 to 1921 are not available, 1914-1918 were war years, 1919-1921, years of inflation

Number of Days of Sickness

Both the number of days of sickness and the average duration of each case of sickness have increased since 1888. In that year the average duration was 16 days for men and 17 days for women, whereas in 1925 (1924) it was 22.5 (23.5) for men and 28 (28.1) for women.

NUMBER OF DAYS OF BENEFIT IN THE FUNDS SUBJECT TO THE FEDERAL INSURANCE CODE ¹

Year	Days of sickness (in thousands)	Days of sickness per case			Days of sickness per insured
		All insured	Men	Women	
1913	—	—	—	—	8.7
1922	177,357	20.3	18.1	23.7	9.7
1923	125,985	20.4	18.6	23.4	7.0
1924	187,479	25.1	23.5	28.1	10.8
1925	228,831	24.3	22.5	28.0	12.5

¹ Statistik der Deutschen Reichs · Wirtschaft und Statistik, 1926, No. 23

Calculation of Basic Wage

It will be remembered that the sickness benefit is equal to a proportion of the basic wage, and that the latter is calculated by wage classes or classes of insured, or by weekly earnings. It may be of interest to show which of these methods is preferred by the funds. According to the official statistics for 1924 covering 7,670 funds, 70 per cent. of the funds fixed the basic wage according to wage classes, 8.7 per cent. according to classes of insured persons, and 27.7 per cent. according to actual earnings; several funds employed several methods simultaneously.

Expenditure on Cash Benefits

The following table shows the total expenditure on cash benefits and the expenditure per insured person:

EXPENDITURE ON CASH BENEFITS IN THE FUNDS SUBJECT TO THE FEDERAL INSURANCE CODE

(a) Total cost in thousands of marks. (b) Cost per insured person, in marks (c) Cost per cent. of total expenditure

Form of benefit	1924			1914		
	(a)	(b)	(c)	(a)	(b)	(c)
Sickness benefit	176,685	11.32	39.7	275,105	15.91	34.8
Family allowances	6,959	0.44	1.6	9,814	0.57	1.2
Benefit to persons treated in hospital	—	—	—	1,934	0.11	0.2
Benefit in place of medical treatment	277	0.02	0.1	5,598	0.33	0.7
Maternity benefit	12,486	0.80	2.8	18,609	1.08	2.4
Nursing benefit				9,778	0.56	1.2
Funeral benefit	10,006	0.64	2.2	10,685	0.62	1.4
Total cash benefits	206,414	13.22	46.4	331,524	19.18	41.9
Total benefits in kind	238,360	15.27	53.6	458,294	26.51	58.1
Total benefits	444,774	28.49	100.0	789,817	45.69	100.0

For miners' sickness insurance the following table has been compiled showing the total expenditure and expenditure per insured person on cash benefits.

EXPENDITURE ON CASH BENEFITS UNDER THE MINERS' SICKNESS INSURANCE SYSTEM

(a) Total cost in thousands of marks (b) Cost per insured person in marks.

Form of benefit	1924	1925
	(a)	(b)
Sickness benefit	32,612	37.21
Family allowances	1,792	2.04
Benefit to persons treated in hospital	9	0.01
Benefit in place of medical treatment	88	0.10
Maternity benefit	978	1.11
Nursing benefit	736	0.84
Funeral benefit	536	0.61
Total cash benefits	36,751	41.92

Additional Benefits

It will be remembered that the Federal Insurance Code authorises various kinds of additional sickness benefit, including the extension of the period of benefit, the increase of the rate of benefit, and the abolition or reduction of the waiting period.

(a) *Extension of the Period of Benefit*

The statutory period during which sickness benefit may be granted is 26 weeks, but this period may be extended by the rules to 52 weeks. The following table shows the extent to which the funds have made use of this power.

EXTENSION OF PERIOD OF BENEFIT

Year	Percentage of total funds which extended the benefit period	
	from 27 to 39 weeks	from 39 to 52 weeks
1914	5.7	3.9
1921	7.7	4.7
1924	11.0	6.7
1925	12.0	7.0

(b) *Increase in Rate of Benefit.*

The legal benefit is fixed at half the basic wage, but by their rules the funds may raise it up to three-quarters of the wage. The following table shows that the funds have made more and more use of this power.

Year	Percentage of total funds which fixed the rate of benefit at	
	50 to 66 $\frac{2}{3}$ per cent. of the basic wage	66 $\frac{2}{3}$ to 75 per cent. of the basic wage
1914	18.2	1.9
1921	26.7	10.4
1924	36.2	9.1
1925	39.2	7.1

(c) *Abolition or Reduction of Waiting Period*

The legal sickness benefit is not due from the first, but only from the fourth, day of incapacity, but this waiting period may be reduced by the rules. About four-fifths of the sickness funds have reduced or abolished the waiting period, but as a rule only under certain conditions. Thus, in general the payment of sickness benefit from the first day is allowed only in cases of incapacity due to an industrial accident, or of prolonged incapacity.

GREAT BRITAIN**Legislation**

ACT OF 7 AUGUST 1924

Rates of Legal Benefit

The rate of sickness benefit is the same for all insured persons, irrespective of earnings, but differs for the two sexes, being 15s. a week for men and 12s. a week for women. The lower rate for women is based on their lower wages and the lower rate of their contributions.

Period of Legal Benefit

Sickness benefit is granted on and from the fourth day of incapacity for work, and for not more than 26 weeks. If at the end of this period the insured person remains unable to work, the sickness benefit is replaced by disablement benefit at 7s. 6d. a week for both men and women. No benefit is payable to persons of over 70 years of age. As from 2 January 1928 this age limit will be reduced to 65.

The following table summarises the rates of benefit fixed in the British Act:

Number of weekly contributions paid	Weekly sickness benefit from the fourth day of incapacity			
	During the first 26 weeks		From the 27th week	
	Men	Women	Men	Women
	s d	s d.	s d.	s d
Under 26	—	—	—	—
26 to 103	9 0	7 6	—	—
104 or more	15 0	12 0	7 6	7 6

For 12 months after a compulsorily insured person has ceased to be employed in an occupation rendering him liable to insurance, or a voluntarily insured person has paid his last contribution, he may claim benefit if he becomes incapable of work during that period, without paying any contributions (section 3).

As already explained, the benefit is payable for not more than 26 weeks. In calculating this period, illnesses are deemed to be continuous unless separated by a period of at least one year (section 13, subsection 5).

Reduction of Legal Benefit

In the case of a compulsorily insured person the weekly sickness (disablement) benefit may be reduced if less than 48 weekly contributions have been paid by or on behalf of the insured person during the year. If less than 26 weekly contributions have been paid by him or credited to his account, he may not claim benefit unless he has paid the prescribed arrears.

The contribution year on which the calculation of the number of contributions paid is based begins about the commencement of July. The contributions paid during the year determine the rate of benefit which the insured person may claim during the "benefit year", i.e. the calendar year beginning six months after the end of the "contribution year". During the interval of six months after the end of the contribution year, the insured person may pay a lump sum graduated according to the arrears, and if he does so before 30 November following the end of the contribution year, he is regarded as a person who has paid 48 weekly contributions, and is therefore entitled to ordinary benefit. For every period of incapacity the contributions are deemed to have been paid (section 15, subsection 3 a). For persons becoming insured after the beginning of a contribution year no account is taken of periods previous to their entry into insurance in calculating the benefit (Arrears Regulations, 1924, para 5). Special provisions were adopted in connection with the Prolongation of Insurance Act, 1921, to provide for the many unemployed workers who, having proved their unemployment, are considered to have paid 26 contributions a year. They may claim benefit at the ordinary rates after having paid the sum fixed for insured persons credited with 26 contributions during the year. The sums to be paid in order to cancel arrears and the reduced rates of sickness (disablement) benefit for compulsorily insured persons are shown in the table below ¹.

¹ *Arrears Regulations, 1924, First Schedule, Part I.*

REDUCTIONS OF BENEFIT AND SUMS TO SECURE FULL BENEFITS FOR
COMPULSORILY INSURED PERSONS

Number of contributions (including weeks of sickness)	Sickness benefit				Disablement benefit, reduction of rate of benefit for men and women	Appropriate sums to secure full benefit	
	Men		Women			Men	Women
	Reduction of ordinary rate	Reduction of rate during first two years of insurance	Reduction of ordinary rate	Reduction of rate during first two years of insurance			
s d.	s d.	s d.	s d.	s d.	s d.	s d.	
45-47	1 0	0 6	1 0	0 6	0 6	1 0	1 0
42-44	2 0	1 0	2 0	1 0	1 0	2 0	2 0
39-41	3 0	1 6	3 0	1 6	1 6	2 0	3 0
36-38	4 0	2 0	4 0	2 0	2 0	4 0	4 0
33-35	5 0	2 6	4 0	2 6	2 6	5 0	4 0
30-32	6 0	3 0	5 0	3 0	3 0	6 0	5 0
26-29	7 0	3 6	5 0	3 6	3 6	7 0	5 0

There is a different scale of arrears for persons who are voluntarily insured, 50 contributions in a contribution year being required in their case to give the full rate of sickness or disablement benefit, or at least 39 to avoid suspension from cash benefits.

No benefit is payable to insured persons who are inmates of a workhouse, hospital, asylum, convalescent home, or infirmary supported by any public authority or out of any public funds, or by a charity or voluntary subscriptions, even if such persons pay for all or part of their maintenance. If, however, they have dependants, the benefit may, at the discretion of the insurance institution, be paid to the members of their family. If they have no dependants, the benefit may be used towards defraying their rent, insurance contributions, or other expenses as insured persons, any surplus being paid in full or in part to the institution supporting them, unless that institution is maintained out of public funds. If any surplus is available after all such payments, it must be paid to the insured person when he leaves the institution, or if he dies in the institution it forms part of his estate (section 17).

Additional Benefits

Any approved society may grant additional benefits on condition that the quinquennial valuation of its assets and liabilities has shown a surplus. Deposit contributors are not entitled to additional benefits.

An approved society may introduce only the additional benefits prescribed in the Act. Within these limits it is free to choose the type of benefit, and must submit its scheme to the Minister of Health for approval (section 75, subsection 1 a and b). The approved scheme remains in operation for five years. The first period of additional benefits, based on the first valuation of 31 December 1918, was from July 1921 to July 1926. For the purpose of the second valuation, the societies were divided into two groups, for which the valuation was made in 1922 and 1923 respectively. For the first of these groups, the period of additional benefit is from July 1925 to July 1930 and for the second from July 1926 to 1931 (*Approved Societies' Handbook*, 1925, paras 649 to 651).

The following are the additional benefits in cash which may be granted (but there are also additional benefits in kind, as to which see page 309).

- (1) An increase of sickness benefit and disablement benefit in the case either of all members of the society or of such of them as have dependants
- (2) A reduction or abolition of the waiting period
- (3) An increase of maternity benefit (Third Schedule of the Act, and *Approved Societies' Handbook*, 1925, para 654)

Additional benefits may ordinarily be claimed only by persons who have been members of the approved society for a minimum period of five years. The maximum additional benefits are not prescribed by the Act, but the Minister of Health advises the approved societies to fix a certain relation between the maximum rates of the different forms of additional benefit, i.e. the additional disablement benefit should be equal to half the additional sickness benefit, and the additional maternity benefit should be double the additional sickness benefit; so that, for instance, a society paying an additional sickness benefit of 5s. a week for men and women alike should fix its maximum additional disablement benefit at 2s. 6d., and the additional maternity benefit at 10s. (*Approved Societies' Handbook*, 1925, para. 654)

Statistics

Expenditure on Sickness and Disablement Benefit

EXPENDITURE ON SICKNESS AND DISABLEMENT BENEFIT* TOTAL AND PER INSURED PERSON

Year	Expenditure on sickness benefit		Expenditure on disablement benefit	
	Total	Per insured	Total	Per insured
	£	£	£	£
1914	6,458,300	0 48	138,900	0.01
1915	5,118,800	0 46	831,700	0.06
1916	4,369,900	0 29	1,107,600	0.07
1917	4,102,100	0 29	1,232,000	0.08
1918	4,887,300	0 31	1,308,600	0 08
1919	5,081,400	0 33	1,396,100	0.09
1920	6,162,800 ¹	0 40	2,001,900 ²	0.13
1921	8,095,800 ²	0 55	3,063,600 ²	0.20
1922	9,215,100	0 61	3,783,300	0.25
1923	8,659,300	0 57	4,253,700	0.28
1924	9,848,700	0 65	4,658,900	0 31
1925	10,347,700	0 66	5,074,200	0.33

¹ As from 1 July 1920, the weekly benefit for men was raised from 10s. to 15s., and for women from 7s. 6d. to 12s.

² As from 4 July 1921, these figures include additional benefits

³ As from 5 July 1920, the weekly disablement benefit was raised from 5s. to 7s. 6d. for men and women alike

Additional Benefits

In the first period of additional benefits, based on the valuation of 31 December 1918, running from July 1921 to July 1926, there were 7,349 approved societies with 14,048,485 members which granted additional benefits, as compared with 1,360 societies with 1,568,245 members which did not.

Out of these 7,349 societies granting additional benefits, 1,140 with 4,728,069 members granted such benefits both in cash and in kind, and 6,941 with 4,652,220 members, in kind only.

In the second period of additional benefits, the 1922 valuation group comprised 922 societies with 3,116 branches and 3,561,000 members, and the 1923 valuation group comprised 76 societies with 3,783 branches and 10,200,000 members

The following table gives information on the kind and amount of the additional cash benefits granted by the societies in the 1922 valuation group, which covered about one-quarter of the total number of insured persons:

Form of additional cash benefit	Number of societies	Membership	Estimated expenditure for the five-yearly period
Sickness benefit granted from the first day of incapacity (abolition of waiting period)	198	277,570	106,154
Increase in normal rate of benefit	3,790	3,344,065	3,107,727
Exemption from payment of arrears of contributions	2,293	1,376,958	71,486
Repayment of contributions	20	45,173	61,480

A comparison of the results of the first and second periods of additional benefits shows that whereas in the first period 93 per cent. of the members of the societies which granted additional benefits could claim such benefit, the proportion had already risen in the second period to 99 per cent. During the first period the sum available per member in societies which realised a profit was £0 65, as compared with about £2 for the second period, a more than threefold increase.

As regards the use made of the sums available for additional benefits during the first period, 71 per cent. were spent on benefits in cash and 29 per cent. on benefits in kind, the corresponding figures for the second period being 52 per cent and 48 per cent. respectively, indicating a marked increase in expenditure on benefits in kind.

HUNGARY

Legislation

ACT XIX OF 6 APRIL 1907

Rates of Legal Benefit

The rate of benefit for the eight wage classes varies according to the period of incapacity, being 60 per cent. of the average wage for the class during the first four weeks, and 75 per cent. as from the beginning of the fifth week.

The rate of benefit is doubled if the fund is not in a position to afford the insured persons medical attendance or drugs (section 55, subs. 4). Apart from these cases the benefit may never exceed actual earnings (Order No. 5,400 of 1919).

The following table shows the rates of benefit for the lowest and highest wage classes respectively in the period 1920-1924.

DAILY SICKNESS BENEFIT

Date	Lowest wage class				Highest wage class			
	During the first four weeks		As from the fifth week		During the first four weeks		As from the fifth week	
	Paper Kr.	Gold Kr.	Paper Kr.	Gold Kr.	Paper Kr.	Gold Kr.	Paper Kr.	Gold Kr.
1 Jan. 1920	1.20	0.03	1.50	0.04	12	0.31	15	0.38
1 Jan. 1921	1.20	0.01	1.50	0.01	36	0.27	45	0.38
1 Jan. 1923	60	0.03	75	0.04	450	0.21	563	0.27
31 Aug. 1923	90	0.01	113	0.02	1,350	0.23	1,688	0.28
21 April 1924	1,620	0.10	2,025	0.13	24,300	1.52	30,375	1.90
31 Aug 1924	6,000	0.34	7,500	0.43	45,000	2.56	56,500	3.21

It will be seen that from 1920 to 1923 sickness benefit was very small. It was not until 1924, after the end of the period of inflation, that there was any rise in real benefit.

Period of Legal Benefit

The period of benefit was originally fixed at not more than twenty weeks, but was raised by Order No. 4790 of 1917 to 26 weeks, and by Order No. 5400 of 1919 to one year. The first two days of sickness are not counted in this period of one year. Benefit is due for the whole year even if the incapacity for work began after the sickness (Order No. 5400 of 1919).

An insured person who has exhausted his right to benefit may claim renewed benefit for the same sickness only after he has worked for at least eight weeks since the cessation of the benefit. If, on the contrary, he has not exhausted his benefit, and has another attack of the same sickness within four weeks of the cessation of the benefit, the new benefit is reckoned as from the beginning of the first sickness (section 64, subsection 2).

Alternative Benefits

In certain cases an insured person may be treated in hospital at the expense of the sickness insurance institution instead of being granted sickness benefit, medical attendance, and drugs. Such a person may not claim other forms of benefit, but the members of his family living in his household who are not themselves insured have the right to half the sickness benefit which he could have claimed if he had not been in hospital.

Reduction of Legal Benefit

An insured person who has wilfully induced his sickness has no claim to sickness benefit. Further, an insured person who continues to receive all his wages for a specified period during sickness may not claim benefit during that period.

According to Order No. 4650 of 1923, the fund may refuse benefit to an insured person who fails to observe the necessary medical instructions, thus delaying his recovery. Moreover, sickness benefit may be refused to an insured person who intentionally evades the prescribed supervision (Order No. 4650 of 1923).

Additional Benefits

Section 51 of the Act of 1907, which empowered the National Fund to raise the sickness benefit up to 75 per cent. of the average wage for not more than a year, is now without practical importance as the legal benefit is 75 per cent. of the average wage except during the first four weeks.

Statistics

Number of Cases of Sickness

The following table shows the number of cases of sickness, and the number per insured.

NUMBER OF CASES OF SICKNESS FOR WHICH BENEFIT WAS PAID BY THE FUNDS AFFILIATED TO THE NATIONAL WORKERS' INSURANCE FUND

Year	Number of cases of sickness	Cases of sickness per cent. of insured		
		All insured	Men	Women
1913	—	35.6	35.5	36.2
1914	—	30.5	30.5	30.4
1919	142,000	22.6	23.9	19.7
1920	132,000	27.5	32.8	16.4
1921	142,000	25.3	28.3	18.4
1922	174,000	26.9	29.4	21.4

Number of Days of Sickness

The preceding table shows that the percentage number of cases of sickness fell considerably as compared with 1913 during the years immediately after the war, which may perhaps be ascribed to the fact that after the war sickness benefit bore no relation to daily wages. That there was no real improvement in the health of the insured will appear from the following table, which shows an increase in the number of days of sickness, as well as in the average duration of each case.

NUMBER OF DAYS OF SICKNESS AND AVERAGE DURATION OF EACH CASE

Year	Days of sickness per case			Days of sickness per insured
	All insured	Men	Women	
1913	19.9	19.2	24.9	7.1
1914	21.0	20.2	25.7	6.4
1919	33.3	29.1	48.2	8.0
1920	31.5	27.6	47.6	8.7
1921	29.8	25.8	43.7	7.5
1922	39.6	26.6	50.8	8.8

Expenditure on Sickness Benefit

EXPENDITURE ON SICKNESS BENEFIT: AVERAGE PER YEAR AND PER MEMBER

Year	Cost of sickness benefit	
	Per member	Per cent. of total receipts
	Kr	
1913	10.21	35.2
1914	8.73	31.8
1919	77	31.0
1920	90	20.4
1921	190	25.0
1922	335	17.8
1923	6,235	14.9
1924	144,274	25.5

IRISH FREE STATE*Legislation*

ACT OF 16 DECEMBER 1911

Rates of Legal Benefit

The rate of benefit is the same for all insured persons, apart from reductions in respect of arrears of contributions.

The weekly benefit is 15s. for men and 12s. for women. If less than 104 weeks have passed since the person in question entered into insurance, and if less than 104 weekly contributions have been paid, the weekly benefit is 9s. for men and 7s. for women.

The disablement benefit, payable as from the twenty-seventh week of incapacity for work, is fixed at 7s. 6d. a week for both men and women, provided that 10½ weeks have passed since their entry into insurance, and that 10½ weekly contributions have been paid

Period of Legal Benefit

Sickness benefit is granted from the fourth day of incapacity for work for a period of twenty-six weeks. If during the twelve months following the end of the sickness there is a second case of sickness, the waiting period is abolished, the sickness benefit being payable from the first day of incapacity. Disablement benefit is payable as from the twenty-seventh week of incapacity for work, and continues as long as the insured person remains unable to work.

Additional Benefit

The provisions with respect to the conditions of granting additional benefits, the persons entitled to these, and the kinds of benefit are similar to those in force in Great Britain

As regards the amount, the additional benefit varies between 1s. and 10s., and differs according as it is an increase on sickness, disablement, or maternity benefit.

Statistics

Expenditure on Sickness and Disablement Benefit

EXPENDITURE ON SICKNESS AND DISABLEMENT BENEFIT: TOTAL AND PER INSURED PERSON

	1924	1925
Total expenditure on sickness benefit	£231,062	£233,132
Total expenditure on disablement benefit	£165,163	£174,483
Expenditure on sickness and disablement benefit per insured person	19s. 11d.	20s. 5d.

For the second valuation period, running from July 1926 to July 1931, out of 80 approved societies in all, only three have introduced additional benefits in cash, while 57 societies, including one with twenty branches, have adopted a mixed scheme of additional benefits in cash and in kind.

ITALY (New Provinces)

Legislation

ACT OF 29 NOVEMBER 1925, No. 2146

Rates of Legal Benefit

Benefit is payable from the fifth day of incapacity and is equal to 50 per cent of the loss of earnings. The benefit is calculated on the wage which was used for determining the insurance contribution

Period of Legal Benefit

Benefit is payable during the sickness up to a maximum of 26 weeks.

Alternative Benefits

An insured person who is treated in hospital and has a family wholly dependent on him is entitled during the period of hospital treatment to a grant equal to half the sickness benefit, or 25 per cent. of the loss of earnings (section 11).

JAPAN

Legislation

ACT OF 22 APRIL 1922

Rates of Legal Benefit

Benefit is paid at the rate of 60 per cent. of the daily remuneration (section 45). In calculating the basic wage account is taken of all payments made at regular intervals, but not of bonuses paid at intervals of more than three months, nor of lodging or rent when not included when the wage is fixed (Order No. 243 of 30 June 1922, par 1)

If the wages are paid in kind, the insured person is classified in accordance with a schedule drawn up by the Insurance Office (Order, par. 2).

The following table shows for each of the 16 wage classes the actual earnings and basic daily wage.

WAGE CLASSES AND BASIC WAGES (SECTION 3)

Wage class	Actual daily earnings	Basic daily wage
	Yen	Yen
1	Up to 0.35	0.30
2	Over 0.35 and up to 0.45	0.40
3	" 0.45 " " " 0.55	0.50
4	" 0.55 " " " 0.65	0.60
5	" 0.65 " " " 0.75	0.70
6	" 0.75 " " " 0.85	0.80
7	" 0.85 " " " 1.15	1.00
8	" 1.15 " " " 1.45	1.30
9	" 1.45 " " " 1.75	1.60
10	" 1.75 " " " 2.05	1.90
11	" 2.05 " " " 2.35	2.20
12	" 2.35 " " " 2.65	2.50
13	" 2.65 " " " 2.95	2.80
14	" 2.95 " " " 3.25	3.10
15	" 3.25 " " " 3.75	3.60
16	" 3.75 " " "	4.00

Period of Legal Benefit

Benefit may be granted for not more than 180 days in respect of the same sickness. Except in cases of industrial accidents and occupational diseases benefit may not be paid for more than 180 days in the same year (section 47).

Alternative Benefits

Instead of medical treatment and sickness benefit the insurance institution may grant treatment and maintenance in a hospital. In this case the sickness benefit is reduced, being fixed at 20 per cent. of the basic wage for insured persons without dependants, 40 per cent. for persons with not more than two dependants, and 60 per cent. for those with three or more dependants (Order, par. 79).

Reduction of Legal Benefit

An insured person who is entitled to his full pay during sickness may not claim benefit. If he receives part of his pay, benefit is granted up to the difference between his sick pay and the normal rate of benefit (Order, par 85).

LITHUANIA

Legislation

ACT OF 23 JUNE 1912

Rates of Legal Benefit

A sick person who is unable to work is entitled to sickness benefit equal to half or all his wages according to his family responsibilities (section 42). The rate of benefit is fixed once a year by the general meeting of the fund (section 43)

Period of Legal Benefit

Benefit is granted from the fourth day of sickness for not more than 26 weeks (section 44).

Alternative Benefits

If the fund grants free hospital treatment, it need not pay sickness benefit (section 48).

If in the opinion of the medical supervisory committee an insured person is considered to suffer from chronic alcoholism, the committee of the fund may pay the sickness benefit to his family or guardian (section 49).

Reduction of Legal Benefit

Insured persons are not entitled to sickness benefit if they wilfully injure themselves, or fall ill while performing unlawful work, or in consequence of a quarrel which they have provoked

LUXEMBURG**Legislation****SOCIAL INSURANCE CODE OF 17 DECEMBER 1925***Rates of Legal Benefit*

Sickness benefit is equal to half the ordinary wages. It is granted for each working day as from the third day after the beginning of the sickness or after the date on which the incapacity for work begins if this is later (section 8, subsection 1).

The benefit is calculated on normal wages, which are taken to be the daily average wages fixed by the rules and classified according to the various rates of wages of the insured persons. A maximum rate is fixed by public administrative regulations at a figure of not more than 12 francs per working day.

Instead of using the average daily wage for the calculation, the rules may take the actual daily wage of the insured persons, up to 12 francs a day.

For voluntarily insured persons the normal wage is defined separately by the rules (section 7).

A change in the normal wage cannot take effect if the claim for benefit has already been submitted (section 18, subsection 2).

Period of Legal Benefit

Benefit is not payable after the twenty-sixth week from the beginning of the sickness or from the day from which benefit was granted if this is later. If for the same sickness the period during which medical attendance is granted interrupts the period of receipt of cash benefit, the former period, to a maximum of 13 weeks, is not included in the duration of the receipt of cash benefit (section 38, subsection 3).

Alternative Benefits

Instead of sickness benefit and medical attendance the fund may grant treatment and maintenance in a hospital. If the sick person has maintained a family wholly or mainly out of his earnings, his dependants are granted benefit equal to half the sickness benefit, which may be paid to them direct (section 9, subsections 1 and 4).

With the consent of the sick person the fund may in certain cases grant him attendance at home by a nurse or nursing sister. In such cases the rules may provide that the cash benefit shall be reduced by not more than one-quarter (section 9, subsection 3).

If an insured person ceases to live in Luxembourg after an event giving the right to benefit the fund may provide by way of the rules for the payment of a lump sum to be fixed in accordance with the regulations drawn up by the central committee (section 23).

*Reduction of Legal Benefit**Coincident Rights to Benefit*

If an insured person receives cash benefit at the same time in respect of another insurance, the rules may provide for the reduction of the benefit to such an extent that the total benefit received does not exceed the average amount of the daily earnings. For this purpose the rules may require insured persons claiming benefit to inform the committee of the sums they receive at the same time in respect of another insurance, but they are not bound to declare under what insurance system they receive such benefit (section 11, 3).

Chronic Diseases

For an insured person who has already received from the fund cash benefit or the benefits substituted for it for 26 weeks consecutively or altogether within 12 months, sickness benefit may be restricted by the rules to the legal benefit and to a total period of 13 weeks if any new sickness due to the same cause as the first occurs during the next 12 months (section 11, 2).

Willfully-Induced Sickness

Finally the rules may refuse benefit in part or altogether for the duration of the sickness if it was incurred intentionally, or by the provocation of, or guilty participation in, a brawl, or for one year from the date of the offence if the insured person has injured the fund by an action entailing the loss of civil rights (section 11, 1).

Additional Sickness Benefits

The Code authorises the introduction by way of the rules of various additional benefits

(1) Extension of the minimum period during which benefit is payable. The rules may extend the duration of sickness benefit up to one year (section 10, 1);

(2) Increase of the legal benefit. The cash benefit may be increased by the rules to not more than three-quarters of the ordinary wage, and the benefit may be made payable for Sundays and holidays (section 10, 4);

(3) Exemption from the waiting period. The rules may provide for the payment of benefit from the first day of incapacity in cases of sickness lasting for more than a week, resulting in death, or due to an industrial accident (section 10, 4);

(4) Cash benefit during hospital treatment. If no family allowance is paid to the families of persons treated in hospital, the rules may provide for cash benefit equal to half the legal minimum benefit in addition to treatment and maintenance in hospital (section 10, 5).

Statistics*Cases of Sickness*

The following table shows the cases of sickness in respect of which cash benefit or hospital treatment was granted by the three types of funds (regional, industrial, mutual benefit). The proportion of cases in which cash benefit was granted is also shown.

CASES OF SICKNESS FOR WHICH CASH BENEFIT OR HOSPITAL TREATMENT WAS GRANTED ¹

Year	Cases of sickness per cent. of insured	Cases of cash benefit per cent. of total cases of sickness
1913	81.93	41.66
1919	68.32	37.20
1920	51.70	30.55
1921	55.82	33.08
1922	56.57	34.94
1923	52.09	32.49

¹ Statistics published by the Department of Agriculture and Social Welfare.

Number of Days of Sickness

The following table shows the total number of days of incapacity for work and the number per member. It also gives the number of days of incapacity with and without cash benefit (waiting period, Sundays and holidays).

DAYS OF SICKNESS WITH AND WITHOUT BENEFIT

Year	Days of sickness		Days without benefit per cent of total days of sickness
	Number (thousands)	Per member	
1918	540	12 25	18.62
1919	440	11 72	14.77
1920	362	9 43	14 91
1921	403	10 50	13.05
1922	449	10.31	13 31
1923	437	9 26	13 79

Expenditure on Cash Benefit

The table below gives the total expenditure of the regional funds on cash benefit including the benefit payable under sections 16 and 19 of the Accident Insurance Act ¹, as also the average benefit per member, per case of sickness, and per day of benefit.

TOTAL EXPENDITURE ON CASH BENEFIT AND EXPENDITURE PER CASE AND PER DAY OF BENEFIT

Year	Expenditure on cash benefit			
	Amount	Per insured	Per case of sickness	Per day of benefit
	Thousands of francs	Francs	Francs	Francs
1913	977	22.51	27.26	2.25
1919	1,837	49.42	71.90	4 92
1920	1,450	38.25	72.96	4.76
1921	2,001	52 88	93.95	5.76
1922	2,157	50.14	88.02	5 58
1923	2,080	44.52	85.09	5.56

Additional Benefits

Section 16 of the 1901 Act authorised various kinds of additional sickness benefit relating to the rate of cash benefit, the maximum benefit period, the abolition or reduction of the waiting period, the payment of cash benefit for holidays, etc.

The following particulars of the extent to which the funds have made use of their powers relate to 1923.

¹ This Act fixes the minimum cash benefit payable to the victims of accidents as from the fifth week of incapacity for work at two-thirds of the average wage. It also requires the funds to pay the victims of accidents suffering from partial incapacity for work an accident pension up to the end of the thirteenth week after the accident, subject to the condition that the pension shall not exceed the sickness benefit which would have been payable for those weeks.

(a) Increase in Rate of Benefit

The rate of cash benefit was fixed at 75 per cent. of the basic wage by five regional funds and 21 industrial funds, i.e. for 19.25 per cent. and 37.87 per cent. respectively of all persons insured in such funds. For the large majority of insured persons the benefit was thus 5 francs a day in regional funds and 7.50 francs a day in industrial funds. Before 1918 the maximum was 3.75 francs.

(b) Extension of the Period of Benefit

For these two types of funds the benefit period was as a rule 26 weeks. This period applied to 76.05 per cent. of the members of regional funds and 75.78 per cent. of those of industrial funds. Further, one industrial fund, representing 12.74 per cent. of the members of such funds, granted benefit for 52 weeks.

(c) Abolition or Reduction of Waiting Period

The maximum waiting period of three days prescribed by the Act was maintained irrespective of the period of the sickness only by six regional funds and six industrial funds, i.e. for 28.03 per cent. and 15.18 per cent. respectively of the members of these types of funds.

(d) Payment of Benefit on Sundays and Holidays

Seventeen industrial funds with 92.15 per cent. of the membership of such funds granted cash benefit on Sundays and holidays, and 11 regional funds with 82.86 per cent. of the membership of these funds granted cash benefit on holidays.

NORWAY**Legislation**

ACT OF 6 AUGUST 1925

Rates of Legal Benefit

Sickness benefit is 60 per cent. of the average daily earnings in the income class of the person insured (section 16, subsection 1, A, c).

INCOME CLASSES AND RATES OF SICKNESS BENEFIT UNDER THE ACT OF 17 JULY 1925

Income class	Average daily earnings	Daily benefit
	Kr.	Kr.
0 ¹	0 ¹	0 ¹
1	1.50	0.90
2	2.50	1.50
3	3.50	2.10
4	4.66	2.80
5	6.00	3.60
6	6.66	4.00

¹ This class is for persons without earnings, those whose annual income is less than 100 Kr., and those who are subject to the Act of 15 February 1918 on Public Employees and Teachers. These persons receive no sickness benefit from the district fund.

Benefit is calculated and paid for all weekdays.

Period of Legal Benefit

Benefit is granted from the fourth day of incapacity for work until the end of the twenty-sixth week, reckoned either from the first day of benefit, or from the first day of hospital treatment if the sick person received no benefit before

being placed in hospital (section 19, subsection 1). In cases of tuberculosis or cancer, benefit is paid for 39 weeks. If an insured person has already received cash benefit for a disease and has one or more further attacks of the same disease, these are regarded as a continuation of the first except in the cases specified in section 19, subsections 3 and 4 (see below). Benefit is paid for not more than 39 weeks altogether for the first and later attacks, but for not more than 26 weeks (39 in cases of tuberculosis or cancer) in any one year reckoned from the beginning of the first payment of benefit. If the payment of the benefit is interrupted, a further payment is in no case allowed until a new attack of the sickness (section 19, subsection 2).

An attack of sickness which begins one year or more after a previous attack of the same kind, and before benefit has been paid for 39 weeks in all is regarded as a new sickness (section 19, subsection 3).

An insured person who has received sickness benefit for 39 weeks in all under section 19, subsection 2, for an attack of the same sickness has no right to benefit for the same sickness before two years have elapsed since the last benefit was paid, reckoned from the end of the last attack, provided that he has been free from the sickness in question during the whole of that period (section 19, subsection 4).

Alternative Benefits

A person treated in hospital receives no benefit, but if he has a wife (or she a husband), or other persons living with him, whom he supports and is bound by law to support, these persons receive cash benefit at the rate of 20 per cent of the full earnings if there is one dependant, 35 per cent. if there are two, and 50 per cent. if there are three or more (section 19, subsection 3).

This benefit for the family is paid for all weekdays from the first day of hospital treatment (section 19, subsection 5).

Reduction of Legal Benefit

An insured person who causes his sickness wilfully or by drunkenness loses all claim to sickness benefit, but the fund may grant the family of such a person while he is treated in hospital the cash benefit specified in section 18, subsection 3. The fund may demand repayment by the insured person of all benefits paid in connection with sicknesses of this kind (section 26, subsection 2).

Statistics

Number of Days of Sickness

DAYS OF SICKNESS FOR WHICH BENEFIT WAS PAID. TOTAL AND PER INSURED ¹

Year	Days of sickness	
	Number	Per insured
1916	2 609,000	6.07
1919	4,133,000	7.61
1920	3,836,000	6.87
1921	3,694,000	6.78
1922	4,386,000	7.69
1923	4,355,000	7.52
1924	4,577,000	7.83

¹ Statistisk Aarboek for Kongeriket Norge.

The above table shows only the days of sickness for which benefit was paid, thus excluding the first three days of the incapacity for work and Sundays. For the district funds it is possible to show the actual number of days of sickness per insured person, all members being taken into account, both men and women, and both compulsorily and voluntarily insured members:

Year	Actual number of days of sickness per insured person
1921	8.58
1922	9.81
1923	9.53
1924	9.84

The average duration of each case of sickness appears to have risen slightly during the last few years:

Year	Average duration of cases of sickness among compulsorily and voluntarily insured persons in the district funds
	Days
1921	30.54
1922	28.45
1923	30.34
1924	32.62

Expenditure on Sickness Benefit

EXPENDITURE OF ALL FUNDS ON SICKNESS BENEFIT: TOTAL AND PER INSURED

Year	Expenditure		Expenditure per insured	
	All benefits	Cash benefits	All benefits	Cash benefits
	Kr. (000's)	Kr. (000's)	Kr.	Kr.
1914	8,324	—	22 2	—
1919	32,963	14,236	57.5	26 21
1920	35,370	12,998	60 5	23 26
1921	37,317	12,746	65 4	23 25
1922	42,018	15,647	70 9	27 43
1923	35,682	13,137	60	22.68
1924	37,206	12,431	62	21 26

POLAND

Legislation

ACT OF 19 MAY 1920

Rates of Legal Benefit

Sickness benefit is fixed for all insured persons at 60 per cent. of the basic wage (section 23, subsection 7).

The insured are grouped according to their wages into fourteen wage classes. As defined by the Decree of 30 June 1924 these classes take the wages into account up to the maxima of 12.50 zloty a day, 75 zloty a week, and 312.50 zloty a month. The average wage on which contributions and cash benefits are calculated for each class is the arithmetic average of the minimum and maximum wages for the class, except in the lowest and highest classes.

For the purpose of classification by wage class, wages are deemed to be those earned during the last four weeks. In calculating benefits and contributions the week is reckoned at seven days and the month at thirty. The wages of an insured person are taken to include any addition to his salary or wages of payments in money such as premiums, percentages, tips, bonuses, and in kind, such as lodging, board, provisions, and clothing, and also sums received from third parties, if these payments are customary and affect the amount of the wages.

Subject to the consent of the Insurance Office, the fund may vary the wage classification defined by the Decree, and in particular may extend the limits of the basic wage above 12.50 zloty and below 1 zloty a day (sections 19, 20 and 21).

Sickness benefit is due for all days of the week.

Period of Legal Benefit

Benefit is granted for each day of the incapacity for work for a period of more than 26 weeks. Funds which have been in existence for more than three years must pay benefit for not more than 39 weeks.

If the insured person begins to draw benefit later than the fourth day of sickness, the 26 (39) weeks are reckoned from the first day of incapacity. If during any period of the sickness the fund supplies only medical attendance, this period is not reckoned in the cash benefit period, and in this case medical attendance may be extended to 39 weeks in any one year.

If during the eight weeks following his recovery an insured person has another attack of the same sickness, this attack is considered to be a continuation of the sickness, and the period of benefit is fixed accordingly.

If an insured person has received benefit from the fund for 26 (39) weeks, whether consecutive or not, during any one year, and if he has another attack of the same sickness during the next twelve months, the fund may reduce the cash benefit period to 13 weeks (section 23, subsections 2-6)

Alternative Benefits

Instead of cash benefit and medical attendance the fund may grant treatment and maintenance in a hospital. A person treated in hospital who is responsible for the maintenance of one or more members of his family wholly or mainly dependent on his earnings is entitled to cash benefit of not more than half the sickness benefit. Sick persons who do not receive this family allowance are granted a daily allowance of 10 per cent. of their basic wage during their hospital treatment (sections 28 and 29).

Reduction of Legal Benefit

Sickness benefit is not payable to an insured person who:

- (a) goes abroad during his sickness without the consent of the committee: this provision applies for the whole period of his stay abroad (section 38 a);
- (b) is imprisoned: this provision applies for the whole period of his imprisonment (section 38 b).

A sick person who refuses to comply with the order of the fund instructing him to enter a hospital because he is suffering from an infectious disease may be deprived of sickness benefit (section 28)

The committee of the fund may refuse or reduce the benefit to insured persons guilty of having caused their sickness intentionally or by participation in brawls. It may accord like treatment to those who injure the fund by punishable acts (section 27).

Additional Benefits

Extension of benefit period: The rules of the fund may increase the benefit period to 52 weeks.

Increase in rate of benefit. The rules may increase the benefit for insured persons with more than two dependent children by 50 per cent. for each child, provided that the total benefit does not exceed three-quarters of the basic wage.

The extension of the benefit period and the increase of the rate of benefit may be made conditional on the period of membership of the insured person in the fund (section 26)

Further, the fund may increase its cash benefits if its income is sufficient to meet the cost of the ordinary benefits and the contribution to the Federation of Sickness Funds, provided that the deductions for the reserve fund have been made and that the reserve is equal in value to the average annual expenditure. The fund *must* grant additional benefits when the reserve fund is double that amount (section 34).

Statistics

Number of Cases of Sickness

The official statistics compiled by the Ministry of Labour and Social Assistance for 1924 show the number of cases of sickness and their distribution by sex and age. The total number of cases of sickness involving incapacity for work was 640,193.

CASES OF SICKNESS INVOLVING INCAPACITY FOR WORK AND DAYS OF BENEFIT SHOWN PER CENT. OF INSURED BY SEX AND AGE GROUPS ¹

Age group	Cases of sickness per cent of insured			Days of benefit (including hospital treatment) per insured		
	Men	Women	All insured	Men	Women	All insured
All insured	36.49	29.85	34.48	6.0	5.4	5.9
Up to 15 years	50.27	48.46	49.65	7.6	7.5	7.6
From 16 to 20 yrs	39.21	31.72	36.29	5.6	5.0	5.4
" 21 " 25 "	36.66	27.08	32.67	5.5	4.8	5.2
" 26 " 30 "	38.72	29.63	35.68	5.9	5.5	5.8
" 31 " 35 "	37.36	31.19	35.66	5.7	5.6	5.6
" 36 " 40 "	35.69	31.72	34.69	6.0	5.9	6.0
" 41 " 45 "	34.48	31.88	33.91	5.7	5.8	5.7
" 46 " 50 "	36.67	30.11	35.43	6.4	6.3	6.4
" 51 " 55 "	38.00	31.31	34.37	6.2	6.9	6.4
" 56 " 60 "	34.67	31.29	34.16	7.7	8.2	7.8
" 61 " 65 "	32.75	26.93	31.88	7.9	8.0	7.9
" 66 " 70 "	33.16	25.33	31.97	9.7	8.8	9.6
" 71 " 75 "	33.37	23.78	31.59	11.4	6.8	10.6
" 76 " 80 "	31.86	26.39	30.55	12.0	7.0	10.8
Over 80	21.49	40.83	26.00	10.2	8.2	9.9
Age unknown	13.97	27.31	16.83	3.8	6.8	4.4

¹ *Sickness Funds in 1924* (official statistics of Ministry of Labour and Social Assistance)

Expenditure on Sickness Benefit

The 153 funds covered by official statistics in 1924 paid out 18,342,784 zloty in cash benefit. For the 135 funds which were in operation during the whole of the year this expenditure was 18,020,824 zloty or 12.87 zloty per insured person. The income of these 135 funds per insured person was 39.64 zloty, so that 21.95 per cent was spent on sickness benefit.

PORTUGAL

Legislation

DECREE OF 10 MAY 1919

Rates of Legal Benefit

Six months after the payment of their first contribution insured persons who have no arrears of contributions are entitled to sickness benefit according to a specified schedule if they fall sick or become unable to work (section 30, subsection 1).

The rate of benefit is fixed according to the wage class and the period of incapacity.

SCHEDULE OF CASH BENEFIT UNDER SECTION 36 OF DECREE

Class of member	Period of benefit	Amount of benefit
		Escudos
First	First 30 days	0 30
	Next 30 days	0 22
	Next 30 days	0 14
	Next 275 days	0 10
Second	First 30 days	0 24
	Next 30 days	0.18
	Next 30 days	0.12
	Next 250 days	0.08
Third	First 30 days	0 15
	Next 30 days	0 12
	Next 30 days	0 08
	Next 250 days	0 06

Period of Benefit

Benefit is granted for not more than 365 days to the members of mutual benefit societies in the first class, and 340 to members in the second and third classes.

ROUMANIA**Legislation**

ACT OF 25 JANUARY 1912

Rates of Legal Benefit

In the former Kingdom and Bessarabia, the benefit granted for incapacity lasting for more than three days varies according to the wage class and family responsibilities of the insured person. For persons with dependants it is 50 per cent of the average annual wage for their wage class, and for other persons 35 per cent. This benefit is paid if he is treated at home. If he is treated in hospital, the benefit for persons with dependants is 25 per cent. of the average wage for their wage class, and for other persons 10 per cent. (section 117, last subsection)

In Ardeal and Bukovina, the sickness benefit is 60 per cent. of the average daily wage for the class to which the insured person belongs

Period of Legal Benefit

In the former Kingdom and Bessarabia, the period during which an insured person who is incapable of work is entitled to benefit is fixed by the Act at 16 weeks (section 117, subsection 1).

In Ardeal and Bukovina, the period of legal benefit is not more than 26 weeks.

Additional Benefits

In the former Kingdom and Bessarabia, an insured person who has exhausted his right to legal benefit and cannot claim invalidity insurance benefits may be granted a special allowance either in cash or in the form of treatment in a sanatorium or nursing home. Provision is also made for an increase in benefits if the reserve fund exceeds the total expenditure for the last five years (section 132, subsection 2).

In Bukovina, the rules may provide for an extension of the legal benefit period of 26 weeks

Statistics

Number of Cases of Sickness

Statistics of the cases of sickness in the former Kingdom are available since the Act of 1912 came into force.

CASES OF SICKNESS PER HUNDRED INSURED IN THE FORMER KINGDOM ¹

Year	Cases of sickness per cent of men insured	Cases of sickness per cent. of women insured (excluding confinements)
1912	10.3	9.0
1913	14.7	13.0
1914	11.8	19.3
1915	9.6	16.6
1916	9.4	14.81
1917	12.55	6.37
1918	18.81	12.85
1919	10.64	16.19
1920	7.36	11.20
1921	7.08	8.76
1922	5.12	7.32
1923	4.23	6.5
1924	6.52	10.8
1925	7.21	12.63

¹ *Buletinul Muncii*, 1926.

Number of Days of Sickness

DAYS OF BENEFIT AND AVERAGE DURATION OF CASES OF SICKNESS

Year	Days of benefit per insured person		Days of sickness per case	
	Men	Women (excluding confinements)	Men	Women (excluding confinements)
1912	1.9	2.1	19.3	25.2
1913	3.5	5.4	24	31
1914	2.8	5.7	24	31
1915	2.3	4.3	24	31
1916	2.9	5.18	30.8	35
1917	2.45	2.43	19.5	38
1918	2.93	1.39	15.6	10.8
1919	2.96	5.01	27.8	31
1920	2.05	3.48	27.9	31
1921	2	2.72	28.2	31
1922	1.55	2.54	30.4	34.7
1923	1.23	2.24	29	34.5
1924	1.99	3.97	30.6	36.8
1925	2.2	4.61	30.5	36.5

Expenditure on Sickness Benefit(a) *Former Kingdom*

TOTAL EXPENDITURE ON BENEFITS AND PROPORTION SPENT ON CASH BENEFIT

Year	Total expenditure on benefits	Percentage of total spent on sickness and maternity benefit
	Lei (000's)	
1912	1,800	25.2
1913	2,848	43.8
1914	1,964	29
1915	1,671	26.4
1916	1,038	23.5
1917	594	25.9
1918	1,328	31.5
1919	2,197	23.2
1920	6,825	21.9
1921	19,905	14.9
1922	29,896	13.3
1923	40,806	16.2
1924	63,232	20.4
1925	76,137	21.4

(b) *Ardeal*

TOTAL EXPENDITURE ON BENEFITS AND PROPORTION SPENT ON CASH BENEFIT

Year	Total expenditure on benefits	Percentage of total spent on sickness and maternity benefit
	Lei (000's)	
1919	8,379	29.8
1920	37,676	37.9
1921	56,001	32.3
1922	76,689	34.2
1923	81,091	33.8
1924	135,769	28.6
1925	122,335	31.2

(c) *Bukovina*TOTAL EXPENDITURE ON BENEFITS AND PROPORTION SPENT ON CASH BENEFITS ¹

Year	Expenditure		Cost per insured
	All benefits	Cash benefit	All benefits
	Lei (000's)	Lei (000's)	Lei
1922	3,741	1,027	151.5
1923	5,359	1,113	172
1924	8,948	1,883	253

¹ *Buletinul Muncii*, 1926.

RUSSIA

Legislation

LABOUR CODE OF 15 NOVEMBER 1922

Rates of Legal Benefit

According to section 179 of the Code, any insured person who temporarily loses his working capacity receives, irrespective of the cause, benefit equivalent to the wage rate due to the class of worker in question in the undertaking or institution concerned at the time of the payment of benefit, and in any case not less than his actual earnings at the date of his loss of working capacity.

At present according to the Regulations of 9 May 1927, the daily benefit is equal to the daily wage. Nevertheless, an Order of the Commissariat of Labour, dated 25 March 1926, has fixed the maximum daily benefit at 7.50 Chervonetz roubles or 180 roubles a month, as from 1 April 1926.

The daily benefit is calculated by dividing the total of the wages and sickness benefit received during the previous three months (or shorter period) by the number of days on which the person concerned worked during the period. The daily benefit is only payable in respect of working days lost (there are special provisions for persons who have in fact fewer rest days than usual).

Period of Legal Benefit

According to section 180, benefit for temporary loss of working capacity is paid from the date of the loss until the date of recovery or of the establishment of the existence of invalidity. So far no fixed rules have been laid down for determining the existence of temporary or permanent invalidity.

Reduction of Benefit

According to section 182, if the available funds are insufficient, the central authorities for social insurance may temporarily reduce the amount of benefit in case of temporary loss of working capacity, provided that the amount of benefit is in no case less than two-thirds of the rate for the class in question.

Statistics

It is not possible to give a table showing the results of the administration of insurance for the whole of the Union of Socialist Soviet Republics (U.S.S.R.). Several of the tables refer to the Russian Federative Socialist Soviet Republic (R.F.S.S.R.) or to one of the large towns, in particular Moscow and Leningrad.

Cases of Sickness

The following table shows the number of cases of incapacity for work (including quarantine and nursing) per cent. of the insured for the whole of the Soviet Union.

NUMBER OF CASES OF INCAPACITY RECORDED BY THE TERRITORIAL FUNDS
PER CENT. OF THE INSURED FOR THE WHOLE OF THE U.S.S.R.

Date	Cases of incapacity per cent of insured		
	Men	Women	All insured
1924:			
January	3.8	4.7	4.1
February	3.9	5.1	4.3
March	4.1	5.3	4.6
April	4.6	6.3	5.1
May	4.5	6.4	5.1
June	4.8	6.6	5.4
July	5.7	6.3	5.9
August	5.3	5.8	5.5
September	5.3	7.0	5.9
October	5.2	6.7	5.7
November	4.5	5.6	4.9
December	5.3	6.8	5.7
	58.3	73.7	63.0
1925:			
January	4.9	6.7	5.4
February	4.7	6.2	5.1
March	4.6	6.2	5.1
April	4.5	6.2	5.0

For the town of Moscow, it is possible to give the number of cases of sickness per cent. of the insured per annum¹.

Year	Cases of sickness		
	Per cent. of men insured	Per cent. of women insured	Per cent. of all insured
1914	25.9	37.9	28.9
1915	32.3	49.7	37.1
1916	30.1	42.3	34.3
1917	30.4	37.2	33.0
1918	43.8	58.0	49.8
1919	64.8	79.2	71.6
1920	88.7	103.9	96.4
1923	75.4	94.6	82.3

Number of Days of Sickness

Three sets of figures are available, relating to the U.S.S.R., the R.F.S.S.R., and the town of Moscow respectively.

¹ Insurance in 1924-1925, p. 32.

NUMBER OF DAYS OF SICKNESS FOR WHICH BENEFIT WAS PAID BY THE TERRITORIAL FUNDS PER CENT. OF THE INSURED IN THE U.S.S.R.¹

Date	Days of benefit per cent. of insured		
	Men	Women	All insured
1924			
January	51.6	65.9	55.8
April	64.8	85.7	70.8
July	82.1	89.4	84.4

¹ *Labour Statistics, 1925, No. 2, and Insurance in 1924-1925, p. 27.*

It should be observed that these figures cover occupational accidents but not confinements.

The corresponding figures for the R.F.S.S.R. distinguish between territorial and transport funds.

DAYS OF BENEFIT PER CENT. OF INSURED IN THE R.F.S.S.R.¹

Date	Days of benefit per cent. of insured					
	Men		Women		All insured	
	Territorial funds	Transport funds	Territorial funds	Transport funds	Territorial funds	Transport funds
1924.						
July	76.3	85.0	87.2	106.9	79.5	86.9
December	57.5	59.3	75.7	64.5	62.9	59.4
1925:						
January	56.3	56.4	76.0	64.6	62.2	56.8
April	56.3	53.5	79.4	72.5	63.2	54.8

¹ *Social Insurance, 1924-1925, p. 30-31.*

Finally, the figures for the town of Moscow show the days of benefit per cent. of the insured.

DAYS OF BENEFIT PER CENT. OF INSURED IN MOSCOW ¹

Year	Days of benefit per cent. of insured		
	Men	Women	All insured
1914	438.5	533.6	462.7
1915	539.4	680.9	578.4
1916	462.3	556.1	495.0
1917	491.1	481.6	487.8
1918	775.5	820.7	794.2
1923	1,140.9	1,413.0	1,239.2

¹ FEINGOLD, *op. cit.*, p. 67.

Information is also available on the average period of absences for temporary incapacity in the U. S. S. R. in 1924. The average period of such absences for which the territorial funds paid benefit was 12.6 days for all insured persons, a figure which appears to have been maintained during the first few months of 1925. The transport funds record corresponding figures of 12.6 for January 1924, 10.2 for April, 10.5 for September, 9.9 for October, and 10.1 for December.

Expenditure on Sickness Benefit

The total expenditure on benefits granted for temporary incapacity (excluding medical attendance) during the six months October 1924 to March 1925 was 46,900,000 chervonetz roubles. During the three months, April to June 1925, the figure was 28,100,000 chervonetz roubles. The cost per insured in 1923 was 5.82 real roubles or about 11.6 chervonetz roubles. According to an estimate for the year 1924-1925, the annual expenditure per insured person on benefit for temporary incapacity was about 20 chervonetz roubles.

It may be of interest to examine the relation between the benefits paid for temporary incapacity and actual earnings, as under the Code the benefit is intended to take the place of earnings.

In the respective months of 1923, the average benefit in the U. S. S. R. was 65.9, 70.5, 67.3, 80.6, 80.8, 85.6, 89.1, 98.2, 84.2, 85.4, 84.6, and 92.8 per cent. of the average wage. During seven years of severe inflation the benefits were calculated in real roubles, according to the cost of living; nevertheless, as the calculations were made monthly according to wholesale prices, benefits sometimes lagged behind wages.

For the first quarter of 1924, the corresponding figure was 92 per cent. of the actual average wage. The rate of benefits were brought into closer correspondence with wages when the calculation was made twice a month. A certain difference between benefits and wages remained even in subsequent years because, on the one hand, the sickness rate was higher among the poorly fed workers and their wives, and, on the other hand, because the maximum benefit was based on a wage of 180 Chervonetz roubles a month.

The figures for the town of Moscow for 1923 are even more favourable, being always above 80 per cent. and for the months July to September being 109.5, 119.2, and 103.6 per cent., suggesting that in that quarter the benefit exceeded wages. A Russian author (Mr. Feingold) points out, however, that the wage statistics do not include certain branches of industry with comparatively high wages. In 1924-1925, the daily benefit varied between 2.45 and 2.55 Chervonetz roubles in Moscow, while the average annual earnings were 782.47 roubles, corresponding to a daily wage of 2.6 or 3.1 roubles according as the year is taken to include 298 or 262 working days. Thus the benefit seems to be slightly less than the average wage.

SERB-CROAT-SLOVENE KINGDOM

Legislation

ACT OF 14 MAY 1922

Rates of Legal Benefit

The sickness benefit is equal to two-thirds of the basic wage for the class to which the insured person belongs. It is payable for all days of the week (section 45, subsection 1.3). As the classification of the insured into wage classes is according to their actual earnings, the sickness benefit is approximately equal to two-thirds of their wages.

Since 1 July 1926, the daily (weekly) benefit has been 1.33 (9.31) dinars for the first or lowest wage class and 32 (224) dinars for the eighteenth or highest class.

Period of Legal Benefit

Sickness benefit is granted for the duration of the incapacity for work reckoned from the date on which the sickness or incapacity began and continued for 26 weeks unless the incapacity ceases earlier (section 45, subsection 1, 3).

Alternative Benefits

The sickness benefit is doubled if the insured person cannot be given medical attendance and drugs. Under certain conditions the insurance institution may provide for treatment of the sick person in hospital. In this case members of his family who do not earn their own living and are members of his household receive half the cash benefit due to him in case of home nursing, for the duration of his hospital treatment (section 54, subsection 5). The term "members of the family" includes the married or unmarried wife, legitimate, illegitimate or adopted children, parents, grandparents, grandchildren, brothers and sisters of the insured person (section 45, subsection 1, 5)

Reduction of Legal Benefit

An insured person who has wilfully brought about his own sickness has no right to cash benefit.

The benefit may be reduced if the insured person wilfully neglects the doctor's instructions and thereby delays his recovery (section 47).

Additional Benefits

The Central Workers' Insurance Institution may, by a decision of its general meeting and if its receipts are sufficient, grant insured persons additional benefits provided that the cash benefit does not exceed the basic wage (section 46, subsection 1, 1), nor lasts more than one year (section 46, subsection 1, 2). The Central Institution may not grant higher benefits or other kinds of benefit.

The additional benefits may be granted by the general meeting, either to all insured persons, or to those belonging to certain local workers' insurance institutions.

By a decision of the committee of the Central Workers' Insurance Institution of 13 July 1923, taken under section 46, sickness benefit (including medical attendance, drugs) may be granted as additional benefit for not more than 52 weeks to insured persons who, during the preceding year, have been insured for not less than six months (Circular of the Central Workers' Insurance Institution of 31 August 1923).

Statistics

Expenditure on Sickness Benefit

COST OF SICKNESS BENEFIT PAID BY THE CENTRAL WORKERS' INSURANCE INSTITUTION ¹

Year	Cost of sickness benefit	
	Amount	Per cent. of total expenditure
	Dinars	
1923	47,756,000	29.99
1924	62,242,000	33.17
1925	56,119,000	26.76

¹ *Radnička Zashita*

SWITZERLAND

Appenzell (Inner Rhodes)

Legislation

ORDER OF 29 NOVEMBER 1920

Rates of Legal Benefit

The daily sickness benefit is 3 francs for compulsorily insured persons resident in the Canton and persons living in the Canton with a permit of residence, and 1 franc for persons temporarily in the Canton (*Aufenthalter*).

Period of Benefit

Benefit is granted only for the period of total incapacity for work as attested by a medical certificate. It is payable at the end of the sickness or once a fortnight as the case may be. It must be used in the first place for providing the necessary treatment at home or in a hospital (section 15)

When an insured person has been treated for 360 days at the charge of the insurance institution, his right to benefit only ceases if the benefit has been granted for at least 180 days in a period of 360 consecutive days.

Appenzell (Outer Rhodes)**Legislation**

ACT OF 30 APRIL 1916

Rates of Legal Benefit

The minimum rate of benefit is 1 franc a day for insured persons of over 14 years of age (section 4).

Period of Legal Benefit

Cash benefit is payable for the period of total incapacity for work as attested by a medical certificate

If the management of the fund considers it necessary, it may hold back the benefit with a view to using it for providing the sick person with the necessary attendance and treatment or with hospital treatment (section 30).

Benefits are payable for 180 days in the course of 360 consecutive days. When an insured person has exhausted his right, he can only claim within the next 360 days benefits for 90 days; if, however, he has received medical treatment for 360 days in the course of the last five years, he can no longer claim any benefit.

If, during a period of 360 consecutive days, an insured person has received benefit for 180 days, he has no right to benefit until the expiration of a further period of 180 days since he last received benefit. In exceptional cases the fund may reduce or abolish this interval on the recommendation of the doctor (sections 29 and 31 of the Order of 30 May 1924).

St. Gall**Legislation**

ACT OF 6 APRIL 1914

Rates of Legal Benefit

The minimum rate of sickness benefit is 4 francs, or for persons temporarily in the Canton (*Aufenthalter*) 1 franc (section 4).

Period of Benefit

Benefit is granted:

- (a) for 180 days in a period of 360 consecutive days;
 - (b) for 90 days after the first 360 days within a further period of 360 consecutive days.
-

CHAPTER III

FUNERAL BENEFIT

In many countries the compulsory system of insurance not only covers sickness, but also provides benefit in the event of the death of the insured. It is not the function of sickness insurance to meet the cost of maintaining members of the deceased's family who were dependent on him when he died or in any way replace the loss of income consequent upon his death: the scope of the funeral benefit provided by sickness insurance is a more limited one, for it is only intended to cover the expenses of burial, either in whole or in part. Benefits of this kind yield no positive social advantage, their purpose is merely to relieve the persons on whom the cost of the funeral would otherwise fall.

In most countries where a compulsory system of insurance is in operation, funeral benefit is a statutory benefit, though of a subsidiary nature. Some insurance systems do not provide for the payment of funeral benefit: such, for instance, is the case in Great Britain and in the Irish Free State, where considerable sections of the population are in the habit of insuring themselves against death for an amount sufficient to cover either funeral expenses alone, or certain other expenses as well resulting from the death of the insured. In these countries therefore it was not considered necessary to include funeral benefit among the statutory benefits.

Funeral benefit is payable, under certain conditions, on the death of the insured or of a person formerly insured: it is payable either to the family of the deceased, or to third parties, whether persons or corporations, who have been responsible for the burial. The rate of benefit is sometimes fixed, while in other cases it varies in proportion to the deceased's earnings. It is proposed to describe the conditions under which benefit is granted, the persons to whom it is granted (beneficiaries), and the amount payable.

Benefits of a different character are payable, under certain compulsory insurance systems, on the death of the husband, wife or child (under age) of the insured, either as a statutory or as an additional benefit. The conditions under which benefit of this

kind is granted, the beneficiaries, and the amount payable will also be described.

The characteristic features of these two forms of benefit will be described in succession in Section 1 of this Chapter.

A summary of the various national legislative provisions relating to funeral benefits, together with the statistics of the operation of these measures (number of deaths in respect of which benefit was paid, aggregate expenditure, and average cost of funeral benefits), will be then dealt with in the second Section.

§ 1. — Conditions under which Funeral Benefit is Granted. Rate of Benefit

BENEFIT IN THE EVENT OF THE DEATH OF THE INSURED

This constitutes a statutory benefit in all countries where insurance is compulsory, except in Great Britain, the Irish Free State, and Portugal.

Conditions under which Benefit is Granted

Benefit is payable on the death of the insured, irrespective of its cause. The period for which the deceased had belonged to an insurance institution is not taken into account, in this connection except in Roumania (former Kingdom), where a qualifying period of 52 weeks is imposed. Conversely benefit is also payable in respect of the death of a person formerly insured, if death occurs within a stated period from the date when the insurance lapsed; a period fixed at two years in the Serb-Croat-Slovene Kingdom; one year in France (Alsace-Lorraine), Germany, Luxemburg, and Norway; six months in Austria, Czechoslovakia, and Poland; and one month in Esthonia. According to certain laws death must, in addition, be attributable to the illness in respect of which the insured had received sickness benefit, and the deceased must have been incapable of work from the time when insurance lapsed until the date of his death; such is the case in France (Alsace-Lorraine), Germany, Luxemburg, Norway, and Poland.

Beneficiaries

Persons entitled to benefit vary according as the benefit is intended merely to cover funeral expenses, or consists, mainly or in part, of a payment to the family of the deceased.

Thus in Esthonia the benefit is only intended to cover funeral expenses, and is payable, without reference to the degree of relation-

ship between the beneficiary and the deceased, to the person who saw to the funeral.

Again, in Czechoslovakia, Japan, and Russia it is payable to the family if it undertook the burial, and in Austria, Chile, and Italy (new provinces) even if the family did not do so.

Thirdly, it is payable to the person or persons by whom the funeral expenses have been defrayed, any surplus being paid to the family: such is the practice in France (Alsace-Lorraine), Germany, Hungary, Latvia, Lithuania, Luxemburg, Norway, and the Serb-Croat-Slovene Kingdom.

Benefit Rates

Statutory benefit rates are generally calculated as a ratio of the deceased's earnings, either as a multiple of the basic daily wage, or a fraction of annual earnings. In Chile and Norway, however, benefit rates do not depend on earnings.

The following table shows minimum rates of funeral benefits paid:

FUNERAL BENEFIT RATES IN THE EVENT OF THE INSURED'S DEATH

Country	Amount of benefit
Austria	30 times basic wage.
Bulgaria	50 " " "
Chile	300 pesos. " " "
Czechoslovakia	30 times basic wage (minimum 150 kr.).
Esthonia	20-30 " " "
France (Alsace-Lorraine)	20 " " "
Germany	20 " " "
Hungary	30 " " "
Italy (new provinces)	20 " " "
Japan	20 " " " (minimum 20 yen).
Latvia	20-30 " " "
Lithuania	20-30 " " "
Luxemburg	$\frac{1}{15}$ of annual earnings Minimum, 20 francs; maximum, 400 francs.
Norway	75 kr.
Poland	21 times basic wage.
Roumania: former Kingdom	250-3,000 lei, according to wage class.
" Ardeal	30 times basic wage.
" Bukovina	210-1,000 lei according to wage class.
Russia	21-45 roubles according to local wage.
Serb-Croat-Slovene Kingdom	30 times basic wage.

The benefit payable may be increased, in the form of additional benefits, to 40 times the basic wage: in France (Alsace-Lorraine), Germany, and Hungary; and to 45 times the basic wage in Austria, Czechoslovakia, and the Serb-Croat-Slovene Kingdom. The minimum benefit payable may also be fixed, under the rules of the insurance institution, at 62.50 francs in France (Alsace-Lorraine), and 50 marks in Germany.

BENEFIT PAYABLE IN THE EVENT OF THE DEATH OF A MEMBER OF THE INSURED'S FAMILY

A wage-earner, in the event of the death of a member of his family dependent on him, is liable for the payment of funeral expenses. This is an economic risk which *must* be covered under certain insurance laws, and *may* be covered under others.

Compensation for the death of a member of the insured's family is a statutory benefit in Czechoslovakia, Lithuania, Poland and Russia; it is an optional benefit, which may be granted under the rules of the insurance institution, in Austria, Esthonia, France (Alsace-Lorraine), Germany, and Hungary.

Conditions under which Benefit is Granted

In Lithuania benefit is payable in the event of the death of the husband or wife, or of a child of the insured who is under age; in Czechoslovakia, Latvia or Poland, on the death of other relatives, i.e. ascendants, brothers and sisters, wards, and illegitimate children, when the latter, not being insured persons themselves, reside in the insured's household, and are mainly or entirely dependent for their maintenance on his earnings. In Russia, benefit is granted on the death of a member of the insured's family, incapable of work and dependent on him: it is payable irrespective of the cause of death.

The rules of the insurance institution may provide for the payment of benefit in the event of the death of the husband or wife, or of a child of the insured in France (Alsace-Lorraine), Germany, and Luxemburg. This is also the case in Austria, Esthonia, Hungary, and the Serb-Croat-Slovene Kingdom in the event of the death of husband or wife, of a child, or any other member of the family. In Austria, however, benefit is only payable if the deceased persons were living with the insured at the time of death, were dependent on him, and were not themselves insured.

Benefit Rates

Benefits vary in accordance with the deceased's earnings and, under some laws, with his age. In Poland this benefit amounts to 50 per cent. of the funeral benefit payable in the event of the death of the insured himself, in other words, to ten and a half times the daily basic wage. In Russia, it amounts to the whole or one-half of the funeral benefit payable in the event of the insured's death, according as the deceased child was over or under

10 years of age. In Czechoslovakia, benefit is fixed at 250, 180, or 60 crowns in accordance as the deceased was over 14, over 2, or not more than 2 years of age. In France (Alsace-Lorraine), Germany, and Luxemburg, the benefit may be either two-thirds or one-half of the funeral benefit payable in the event of the insured's death, according as it is payable in respect of the death of the husband or wife, or of a child of the insured. In Hungary, the benefit must not exceed 20 times the daily basic wage of the insured, and, in the Serb-Croat-Slovene Kingdom, must not in any case exceed the funeral benefit payable in the event of the death of the insured person himself.

§ 2. — Summary of Legislative Provisions in Various Countries: Results of their Application

AUSTRIA

Legislation

AMENDED TEXT OF THE ACT OF 30 MARCH 1888 PROMULGATED BY THE ORDER
OF 20 NOVEMBER 1922

Benefit Payable on the Death of the Insured

Conditions under which Benefit is Granted

Benefit is payable on the death of the insured irrespective of its cause. It is also payable on the death of a person formerly insured whose right to pecuniary sickness benefit had not expired more than six months previously (section 6 (5)).

Beneficiaries

Benefit is payable to the dependants of the insured; where there are no dependants, the funeral benefit is used to cover the funeral expenses up to the amount of such expenses. Any surplus shall revert to the fund (section 6 (5)).

Amount of Benefit

Benefit amounts to 30 times the average daily earnings. Funeral benefit may be increased, as an additional benefit and under the rules of the fund, to 45 times the average daily earnings, but must not exceed 150 schillings (sections 6 (5) and 9 (4)).

Benefit Payable on the Death of a Member of the Family

This form of benefit is not compulsory; it may be granted in the event of the death of members of the insured's family living with him permanently and mainly supported by him and who are not themselves compulsorily or voluntarily insured. The amount of benefit is determined by the rules of the fund (section 9 (a)).

Statistics

NUMBER OF DEATHS IN RESPECT OF WHICH BENEFIT HAS BEEN PAID

The following table indicates the number of deaths in respect of which benefit has been paid per 1,000 insured persons of both sexes.

NUMBER OF DEATHS PER 1,000 INSURED PERSONS WHERE BENEFIT WAS PAID ¹

Year	Number of deaths per 1,000 insured persons	Year	Number of deaths per 1,000 insured persons
1915	10.5	1921	8.9
1916	11.7	1922	8.7
1917	14.3	1923	8.2
1918	19.7	1924	8.1
1919	15.2	1925	8.2
1920	11.3		

The number of deaths in respect of which funeral benefit has been paid by sickness insurance funds has since the war fallen steadily.

COST OF FUNERAL BENEFIT

The aggregate expenditure and the expenditure per insured person involved in the payment of funeral benefit is shown in the following table; the data for years previous to 1923 have no value for the purpose of comparison in view of the currency conditions which prevailed.

AGGREGATE EXPENDITURE AND EXPENDITURE PER INSURED ¹

Year	Total expenditure	Expenditure per insured person
1919	3.1	4.2
1923	3,907	3,409.3
1924	9,656	7,734.4
1925	1.4 million schillings	1.13 schillings

¹ Bulletin of the Ministry of Social Administration.

BULGARIA

Legislation

ACT OF 6 MARCH 1924

Benefit Payable on the Death of the Insured

Conditions under which Benefit is Granted

Benefit is payable where an insured person dies in consequence of sickness (section 22). Benefit is payable in the event of death as soon as a person has insured.

Beneficiaries

Benefit is payable to the survivors of the deceased. Survivors are not defined in the Act; they, however, presumably include the widow, children, father or mother, brothers or sisters of the insured who are dependent on him

Amount of Benefit

The benefit payable amounts to 50 times the basic daily wage of the deceased, viz. to 600, 800, 1,000, 1,250, or 1,500 levas, in accordance with the wage category of the deceased (sections 10, para. 2, and 12, para. 3).

CHILE**Legislation**

ACT OF 8 SEPTEMBER 1924

Benefit Payable on the Death of the Insured

On the death of an insured person his family becomes entitled to a payment of 300 pesos for funeral expenses. If the insured person has no family living with him, the fund defrays the funeral expenses. But if any relative or friend of the deceased, or any trade associations or organisation to which he belonged, offers to pay the funeral expenses, that offer must be accepted (section 14 (d))

CZECHOSLOVAKIA**Legislation**

ACT OF 9 OCTOBER 1924

*Benefit Payable on the Death of the Insured**Conditions under which Benefit is Granted*

Funeral benefit is payable on the death of an insured while still a member, or during the period when he was entitled to sickness benefit, or if he died less than six months after the date on which his claim to pecuniary sickness benefit ceased (sections 95, III (1), and 97 (4) and (5)).

Beneficiaries

Funeral benefit is payable to members of the family who have defrayed the expenses of the burial of the insured person.

The following are deemed to be members of the family: persons living in the same household with the insured person, mainly dependent upon his wages, and not entitled to benefit on account of their own insurance: wife or husband, legitimate and illegitimate children, stepchildren, adopted children and foster children under 17, older children, grandchildren, brothers and sisters, parents, grandparents, parents-in-law who have lived in the household of the insured person for at least six months before the occurrence of the event giving rise to benefit (sections 95, III (1) and 96, (1)).

In default of members of the family as above specified, funeral benefit is applied to defray the expenses of burial up to the amount thereof (section 95, III (1)).

In case of a claim to funeral benefit under the Act which coincides with a claim to it under the legal provisions relating to accident insurance for workers, the sickness insurance claim is cancelled up to the amount of the accident insurance claim (section 95, III, last paragraph).

Amount of Benefit

The statutory benefit amounts to 30 times the average daily wage of the insured at the time of death or of his ceasing to be an insured person, provided this amount does not fall below 150 crowns.

Amount of Benefit according to the Rules of the Fund

The rules of a sickness insurance institution may provide that the funeral benefit shall be increased to 45 times the average daily wage, provided the general provisions relating to the grant of additional benefits have been complied with (section 105, 1 (d))

*Benefit on the Death of a Member of the Insured's Family**Conditions under which Benefit is Granted*

Funeral benefit is paid to an insured person who pays the expenses of burial of a member of his family (section 95, III (2)). The following persons living in the same household with the insured person, mainly dependent upon his wages and not entitled to benefit on account of their own insurance, are deemed to be members of the family:

- (a) wife or husband;
- (b) legitimate and illegitimate children, stepchildren, adopted children, and foster children under 17;
- (c) older children, grandchildren, brothers and sisters, parents, grandparents and parents-in-law who have lived in the household of the insured person for at least six months before the occurrence of the event giving rise to benefit.

The fact that any of the above persons live apart from the household for the purpose of bringing up the children, because of the housing shortage, or from considerations of health, domestic economy, or education, or other reasons independent of their personal relations, is not deemed to constitute non-fulfilment of the requirements as to residence in the same household (section 96 (2))

Amount of Benefit

The amount of funeral benefit due in respect of the burial of a member of the family is fixed at 60 crowns for a member not more than two years old, 180 crowns for a member not more than 14 years old, and 250 crowns for an older person. Nevertheless the funeral benefit for a member of the family must not be higher than the funeral benefit for the insured person himself (section 95, III (2))

Statistics**NUMBER OF DEATHS IN RESPECT OF WHICH BENEFIT HAS BEEN PAID**

Information regarding the number of cases of death where funeral benefits have been paid by funds is available for Bohemia, Moravia, and Silesia on the one hand, and for Slovakia and Sub-Carpathian Russia on the other.

In the former group of provinces benefit was paid by funds, per 1,000 insured workers, as follows;

1920	8.6	1923	6.6
1921	7.7	1924	6.6
1922	7.7		

In Slovakia and Sub-Carpathian Russia the corresponding figures were:

1923	5.6	1924	6.3
			(Statistics of the Ministry of Social Welfare.)

A constant decrease in the relative number of deaths in respect of which funeral benefits were paid by sickness insurance funds will be noted.

COST OF FUNERAL BENEFIT

The following table shows the aggregate cost and the average cost per death since 1920 of funeral benefit for Bohemia, Moravia, and Silesia :

TOTAL EXPENDITURE AND EXPENDITURE PER DEATH IN BOHEMIA,
MORAVIA AND SILESIA

Year	Expenditure		
	Total (in 1,000 crowns)	Per death (in crowns)	Per insured person (in crowns)
1920	4.4	262	2.25
1921	11.5	732	4.86
1922	15.1	720	7.12
1923	12.8	674	5.93
1924	13.2	—	—

As regards Slovakia and Sub-Carpathian Russia, the total cost of funeral benefit was as follows:

	Crowns		Crowns
1920 . . .	388,000	1923 . . .	1,630,000
1921 . . .	1,329,000	1924 . . .	1,731,000
1922 . . .	1,775,000		

(Statistics of the Ministry of Social Welfare.)

ESTHONIA

Legislation

ACT OF 23 JUNE 1912

*Benefit Payable on the Death of the Insured**Conditions under which Benefit is Granted*

Funeral benefit is payable irrespective of the period during which the deceased had been a member of the fund. A member retains his right to funeral benefit for a period of one month after his membership has ceased (section 279)

Beneficiaries

Funeral benefit is paid to the person or persons who have undertaken the funeral. Members of the deceased's family do not enjoy any advantage or priority in this respect (section 313).

Amount of Benefit

The statutory benefit varies from 20 to 30 times the daily basic wage of the deceased (section 313).

Benefit Payable on the Death of a Member of the Deceased's Family

Insurance funds are empowered to grant funeral benefit in the event of the death of a member of the insured's family dependent on him (section 299)

Nevertheless, the amount applied to the provision of family benefits must not exceed more than one-third of the total annual contributions from employers and workers (section 299).

Statistics

NUMBER OF DEATHS IN RESPECT OF WHICH BENEFIT HAS BEEN PAID

The number of cases of death where benefit was paid was as follows; per 1,000 insured:

in 1923	. . .	5.8
in 1924	.	5 1

COST OF FUNERAL BENEFIT

The aggregate cost involved in the payment of funeral benefit amounted to:

1,360,500	Esthonian marks	in 1923
1,371,370	„ „	„ 1924

(Communication from the
Central Statistical Office
of Esthonia.)

FRANCE (Alsace-Lorraine)

Legislation

GERMAN SOCIAL INSURANCE CODE OF 19 JULY 1911

Benefit Payable on the Death of the Insured

Conditions under which Benefit is Granted

If a sick person dies of his illness within one year of the exhaustion of the sickness benefit in respect of it while still a member of the fund, funeral benefit is paid, provided he remained incapable of work (with reference to his former occupation) until his death (section 202).

Beneficiaries

The expenses of burial are defrayed in the first instance out of the funeral benefit and paid to the person who provided for the burial. If there is any surplus, the husband or wife, children, father, mother, and brothers or sisters are entitled to receive it, provided they were members of the deceased's household at the time of his death. In default of such claimants the surplus reverts to the fund (section 203).

Amount of Benefit

Twenty times the basic wage of the deceased is the amount paid as funeral benefit (section 201).

An amount not exceeding 40 times the daily basic wage may be fixed by the rules of the fund and which may also prescribe a minimum of 62.50 francs.

Benefit on the Death of a Member of the Deceased's Family

Benefit of this kind may be granted, under the rules of the fund, in the event of the death of the husband or wife, or a child of the insured. It must not exceed two-thirds of the funeral benefit, in the former case, and one-half in the latter: the amount of benefit to which the deceased was entitled in virtue of being a compulsorily insured person must in all cases be deducted from the amount payable (section 205).

Statistics

NUMBER OF DEATHS IN RESPECT OF WHICH BENEFIT HAS BEEN PAID

The number of deaths for which benefit was paid was, per 1,000 insured persons, as follows:

1919	13	1922	11
1920	11	1923	12
1921	12		

COST OF FUNERAL BENEFIT

The following table shows the aggregate expenditure, on the one hand, and the average expenditure per death and per insured, on the other:

Year	Cost		
	Total (in 1,000 francs)	Per case of death (in francs)	Per insured (in francs)
1919	601	139	1.7
1920	685	159	1.8
1921	1,053	229	2.7
1922	1,189	252	2.8
1923	1,217	238	2.7

(Bulletin de l'Office général des Assurances sociales d'Alsace et de Lorraine.)

The increase in the expenditure noted is attributed to currency depreciation.

ADDITIONAL BENEFITS

The statutory benefit amounts to 20 times the daily basic wages; benefit may, however, be fixed under the rules at 40 times the daily basic wage, and a minimum of 62.50 francs may be prescribed.

As shown in the following table, insurance funds have increasingly taken advantage of this permission.

INSURANCE FUNDS WHERE AN ADDITIONAL FUNERAL BENEFIT IS GRANTED

Year	Total number of funds	Funds where benefit varying	
		from over 20 to 30 times the basic wage is granted	from over 30 to 40 times the basic wage is granted
1919	264	59	6
1920	257	85	16
1921	252	84	20
1922	247	87	18
1923	247	91	18

(Bulletin de l'Office général des Assurances sociales d'Alsace et de Lorraine.)

**FUNERAL BENEFIT PAYABLE ON THE DEATH OF A MEMBER OF THE
INSURED'S FAMILY**

Funds are empowered under their rules to grant benefit in the event of the death of the husband or wife, or of a child of the insured. As shown in the following table, nearly one-half of the funds have made use of this permission.

**FUNDS IN WHICH FUNERAL BENEFIT ON THE DEATH OF THE HUSBAND
OR WIFE OR OF A CHILD OF THE INSURED IS GRANTED**

Year	Total number of funds	Number of funds paying funeral benefit on the death	
		of the husband or wife	of a child
1919	264	87	73
1920	257	87	77
1921	252	87	80
1922	247	110	100
1923	247	120	102

*(Bulletin de l'Office général des Assurances
sociales d'Alsace et de Lorraine.)*

GERMANY

Legislation

**NOTIFICATION OF THE NEW TEXT OF THE FEDERAL INSURANCE CODE,
15 DECEMBER 1924**

Benefit Payable on the Death of the Insured

Conditions under which Benefit is Granted

Funeral benefit is payable on the death of an insured person (section 201); it is due irrespective of the cause of death.

In certain cases benefit is payable in the case of the death of a person formerly insured; thus, if a sick person dies of his illness within one year of the exhaustion of the sickness benefit in respect of it, while still a member of the fund, the funeral benefit must be paid, provided that he remained incapable of work until his death (section 202).

Beneficiaries

The expenses of burial are to be defrayed in the first instance out of the funeral benefit and paid to the person who provided for the burial. If there is any surplus, the husband or wife, child, father, mother, brothers, and sisters are entitled to receive it, provided that they were members of the household of the deceased at the time of his death. In default of such claimants, the surplus reverts to the fund (section 203). Although third parties are not entitled to the repayment of funeral expenses beyond the amount of benefit payable, the persons specified above as being entitled to benefit are entitled to the whole of it, even if no funeral has taken place nor any funeral expenses have been incurred.

Claimants are not required to prove that they were members of the deceased's household, provided they were living under the same roof

Amount of Benefit

The pecuniary benefit is calculated according to a basic wage and amounts to 20 times that wage (sections 180 and 201). The basic wage at the time of death is taken as a basis in making this calculation, except in the case

provided for in section 202 (death of a person formerly insured), where the wage taken as basis is the basic wage at the date of illness.

Under the rules of a fund, funeral benefits may be fixed at 40 times the basic wage and, on the other hand, the minimum amount may be fixed at not more than 50 marks (section 204).

Benefits on the Death of a Member of the Insured's Family

Conditions under which Benefit is Granted

The rules may provide for the payment of funeral benefit on the death of the husband or wife or a child of the insured (section 205 *b* (2)). Benefit of this kind cannot be granted in respect of any other members of the family, it is payable irrespective of the cause of death.

Amount of Benefit

The benefit may be fixed for the husband or wife at not more than two-thirds, and for a child at not more than one-half, of the funeral benefit for the insured; and shall be reduced by the amount of the funeral benefit for which the deceased person himself was insured according to law (section 205 *b* (2)).

Statistics

NUMBER OF DEATHS

The number of deaths in respect of which benefit was paid per 1,000 insured persons is indicated, for the two sexes separately, since 1922, in the following table.

NUMBER OF DEATHS IN RESPECT OF WHICH BENEFIT WAS PAID PER THOUSAND PERSONS INSURED IN INSURANCE FUNDS ADMINISTERED UNDER THE FEDERAL INSURANCE CODE

Year	Number of deaths in respect of which benefit was paid per 1,000 insured persons		
	Men and women	Men	Women
1922	6.9	7.9	5.4
1923	6.4	7.2	5.0
1924	6.5	7.2	5.4
1925	6.2	6.9	5.1

(Statistik des Deutschen Reichs. Wirtschaft und Statistik, 1926, No. 23.)

COST OF FUNERAL BENEFIT

The expenditure per death and the average cost of funeral benefit per insured person, including the benefits payable in respect of the death of a member of the insured's family, are indicated in the following table.

AGGREGATE EXPENDITURE AND AVERAGE COST OF FUNERAL BENEFIT PER DEATH AND PER INSURED PERSON

Year	Expenditure		
	Totals (in 1,000 marks)	Per death (in marks)	Per insured (in marks)
1914	10,000	—	0.64
1924	10,686	67.80	0.61
1925	14,461	89.73	0.79

(Statistik des Deutschen Reichs. Wirtschaft und Statistik, 1926, No. 23.)

ADDITIONAL BENEFITS

The legal benefit is fixed at 20 times the daily basic wage. Funeral benefit may, however, be increased, by the rules of the fund, to not more than 40 times the basic wage; while the minimum amount may be fixed at not more than 50 marks.

It is interesting to note what use has been made of the option to increase the funeral benefit rate beyond the legal minimum.

NUMBER OF FUNDS IN WHICH AN ADDITIONAL FUNERAL BENEFIT IS GRANTED

Year	Per cent of funds which have raised the funeral benefit to		
	more than 20 times the basic wage	more than 20 but not more than 30 times the basic wage	more than 30 but not more than 40 times the basic wage
1914	34.9	29.4	5.5
1921	43.1	32.4	10.7
1924	53.9	37.9	16.0
1925	56.6	39.7	16.9

(Statistik des Deutschen Reichs.)

Funds are more and more having recourse to the permission to increase the amount of funeral benefit to more than 20 times the daily basic wage.

The official information on this point given above may usefully be supplemented by that supplied by the two principal federations of local sickness insurance funds, the "Hauptverband deutscher Krankenkassen" and the "Gesamtverband der Krankenkassen Deutschlands".

It is stated (on p. 283) of the *Jahrbuch der Krankenversicherung* (1925), issued by the Hauptverband deutscher Krankenkassen, which gives information relating to 986 local sickness insurance funds having a total membership of 8,692,934, that funeral benefit rates were fixed by the rules as follows in 1925.

at 25 times the daily basic wage by 84 funds with a membership of 547,383;
 at 30 times the daily basic wage by 358 funds with a membership of 3,919,756;
 at 35 times the daily basic wage by 8 funds with a membership of 147,884;
 at 40 times the daily basic wage by 150 funds with a membership of 2,110,813.

The report issued by the "Gesamtverband der Krankenkassen Deutschlands" for 1925, relating to 363 funds with a membership of 1,618,558, states that funeral benefit rates were fixed by the rules at more than 20 times the daily basic wage in the case of 47.9 per cent. of the funds, with a membership of 53.9 per cent. of the total membership (*Geschäfts- und Kassenbericht des Gesamtverbandes der Krankenkassen Deutschlands für das Jahr 1925*, p. 47).

According to the *Jahrbuch der Krankenversicherung* (1925, p. 283), the minimum funeral benefit rates were, in accordance with section 204 of the Code, laid down as follows:

10 marks by 6 funds with 16,319 members;
 20 marks by 25 funds with 90,124 members;
 30 marks by 72 funds with 525,487 members;
 40 marks by 24 funds with 224,397 members;
 50 marks by 391 funds with 4,828,400 members.

BENEFIT PAYABLE ON THE DEATH OF A MEMBER OF THE FAMILY

The rules may provide for the payment of funeral benefit in the event of the death of the husband or wife, or the child of the insured; benefit in the former case must not exceed two-thirds, and in the latter one-half, the funeral benefit payable in respect of the death of the insured.

NUMBER OF FUNDS WHERE FUNERAL BENEFIT IS PAID IN THE EVENT OF THE DEATH OF A MEMBER OF THE FAMILY

Year	Per cent of 100 funds which pay benefit on the death of	
	husband or wife	child
1914	by 34	by 28.4
1919	„ 35	„ 29.8
1920	„ 42.5	„ 37.5
1921	„ 50	„ 41.6
1924	„ 61.1	„ 57.9
1925	„ 63.4	„ 60.3

(Statistik des Deutschen Reichs.)

Since 1924 most of the funds administered under the provisions of the Insurance Code grant benefit in the event of the death of the husband or wife, or a child of the insured.

The *Jahrbuch der Krankenversicherung* for 1925, which covers 986 local sickness insurance funds with an average membership of 8,692,934, states that 604 funds with a membership of 6,621,665 have introduced the payment of funeral benefit in the event of the death of the husband or wife, or a child of the insured. In 604 cases the rules of the fund provide that the benefit in the event of the death of the husband or wife shall consist of the following percentage of the funeral benefit payable in the event of the insured's death.

In respect of	60,729 insured at 20 per cent of funeral benefit.
„ „ „ 731,444	„ „ 33 $\frac{1}{3}$ „ „ „ „
„ „ „ 322,713	„ „ 40 „ „ „ „
„ „ „ 4,032,668	„ „ 50 „ „ „ „
„ „ „ 188,582	„ „ 60 „ „ „ „
„ „ „ 1,511,668	„ „ 66 $\frac{2}{3}$ „ „ „ „

In the event of the death of a child of the insured the benefit amounted to the following percentages of the funeral benefit for the insured himself;

Not exceeding 10 per cent in respect of	101,073 insured.
„ „ 12 $\frac{1}{2}$ „ „ „ „	43,214 „
„ „ 15 „ „ „ „	291,641 „
„ „ 20 „ „ „ „	815,589 „
„ „ 25 „ „ „ „	2,349,260 „
„ „ 33 $\frac{1}{3}$ „ „ „ „	1,905,609 „
„ „ 40 „ „ „ „	221,893 „
„ „ 50 „ „ „ „	1,055,824 „

(*Jahrbuch der Krankenversicherung*, 1925, pp. 285-286.)

The report of the "Gesamtverband der Krankenkassen Deutschlands" for 1925 (p. 47) states that 60.8 per cent. of the funds, with a membership of 75.3 per cent. of the total membership, granted benefits in the event of the death of a member of the family of the insured, viz 55.6 per cent of the funds, with a membership of 71.5 per cent. of the total, on the death of the husband or wife or a child of the insured, and 5.2 per cent. of the funds, with a membership of 3.8 per cent. of the total, on the death of the husband or wife only.

HUNGARY**Legislation**

ACT No. XIX OF 6 APRIL 1907

*Benefit Payable on the Death of the Insured**Conditions under which Benefit is Granted*

Funeral benefit is payable in the event of the death of the insured irrespective of its cause. The right to benefit commences from the date of insurance.

Beneficiaries

The benefit is the property of the husband or wife or, in their absence, of the legal heirs of the deceased. If other persons arrange for the funeral, they shall be entitled to receive as benefit an amount not exceeding the actual funeral expenses. Where the deceased died without leaving relatives, the local fund must take charge of his funeral, subject to the provision that the expenses shall not exceed the benefit payable.

Amount of Benefit

This is fixed at 30 times the daily basic wage (section 50 (6) of the Act: and Order 4,790 of 1919).

The National Insurance Fund is empowered to increase funeral benefit to 40 times the average daily wage corresponding to the wage category to which the insured belonged (section 51 (1)).

Benefit Payable on the Death of a Member of the Insured's Family

This constitutes an additional benefit which may be granted by the National Insurance Fund in the event of the death of a member of the insured's family. The amount may be fixed at 20 times the average daily wage of the insured (section 51)

Statistics**NUMBER OF DEATHS**

The following table shows the number of deaths per 1,000 insured persons of both sexes in respect of which benefit was paid, the figures being given separately for each sex.

NUMBER OF DEATHS PER 1,000 INSURED PERSONS WHERE BENEFIT WAS PAID

Year	Number of deaths per 1,000 insured persons where benefit was paid		
	Men and women	Men	Women
1913	7	7	6
1919	7	8	5
1920	9	11	5
1921	7	8	4
1922	8	9	5

(Report on the Administration of the Workers' National Insurance Fund, Budapest)

COST OF FUNERAL BENEFIT

Information relating to the aggregate cost of funeral benefits during the period of currency inflation, which prevailed from 1919 to 1924, is of little or no interest as is sufficiently shown by the fact that the average cost of

funeral benefit per insured person increased during that period, from 0.46 kronen in 1913 to 2.9 kronen in 1919, 17 kronen in 1922 and 6,159 kronen in 1924.

ITALY (New Provinces)

Legislation

ACT OF 29 NOVEMBER 1925

Benefit Payable on the Death of the Insured

No qualifying period is imposed before an insured person becomes entitled to funeral benefit. The amount of the latter is fixed at 20 times the daily wage last earned by the deceased, and is payable to the widow, children or other persons dependent on the deceased (section 6)

JAPAN

Legislation

ACT OF 22 APRIL 1922

Benefit Payable on the Death of the Insured

Funeral benefit is payable irrespective of the cause of death or the period during which the deceased had been insured. It is payable to that member of the deceased's family who arranges for the funeral, and amounts to 20 times the daily remuneration of the insured, subject to a minimum of 20 yen (section 49).

LATVIA

The legal provisions resemble those in force in Esthonia, see page 261.

LITHUANIA

Legislation

ACT OF 23 JUNE 1912

Benefit Payable on the Death of the Insured

Benefit is payable, irrespective of the cause of death, to the person arranging for the funeral: any surplus is paid to members of the deceased's family who were members of his household. In the absence of members of the insured's family, the surplus reverts to the funds (section 61). Benefit varies from 20 to 30 times the daily basic wage of the deceased (section 60).

Benefit Paid in the Event of the Death of a Member of the Insured's Family

Benefit is granted in the event of the death of the husband or wife, or a child of the insured (section 64 (2)). The amount of benefit is fixed by the fund: nevertheless, the total amount applied to the provision of family benefits of all kinds must not exceed one-third of the contributions of employers and workers received in the course of the year (section 65).

LUXEMBURG

Legislation

SOCIAL INSURANCE CODE OF 17 DECEMBER 1925

Benefit Payable on the Death of the Insured

Conditions under which Benefit is Granted

The right to benefit commences, as regards compulsorily insured persons, from the date when they became insured (section 16 (1)). In certain cases

the right to benefit continues even after membership of the fund has ceased; if a person falls sick and dies as a result of this sickness within a year from the date when his right to sickness benefit ceased, funeral benefit is payable provided the deceased had remained incapable of work from that date until the date of his death (section 14 (3)).

Beneficiaries

The benefit must be used for the purpose of repaying any funeral expenses which have been incurred, and a sum not exceeding that amount is paid to the person who undertook the funeral. Any surplus is paid to the father, mother, brothers, or sisters, in that order, provided the persons in question were members of the deceased's household at the time of his death (section 14 (2)).

Amount of Benefit

This is fixed at one-fifteenth of the annual earnings of the deceased, but must not exceed 400 francs or fall below 200 francs (section 14 (1)).

Benefit Payable on the Death of a Member of the Insured's Family

Benefit may be granted in the event of the death of the husband or wife, or a child of the insured. In the former case it must not exceed two-thirds and in the latter case one-half of the funeral benefit payable in the event of the death of the insured himself. Such benefit is reduced by the amount of any funeral benefit payable by a sickness insurance fund, an accident insurance association, or an old-age and invalidity insurance institution, if the deceased was insured (section 15 (1), (2)).

Statistics

NUMBER OF DEATHS IN RESPECT OF WHICH BENEFIT HAS BEEN PAID

The number of cases, per 1,000 insured persons, where benefit was granted by a local or industrial insurance fund are as follows.

		Deaths			Deaths
In 1919	. . . . .	9.7	In 1922	. . . . .	6.4
„ 1920	. . . . .	9.7	„ 1923	. . . . .	6.3
„ 1921	. . . . .	6.9	„ 1924	. . . . .	5.9

(*L'Assurance-maladie dans le Grand-Duché de Luxembourg.*)

COST OF FUNERAL BENEFIT

The information relating to the aggregate cost and the average cost per insured of funeral benefit is embodied in the following table.

TOTAL EXPENDITURE AND EXPENDITURE PER INSURED

Year	Aggregate cost (in 1,000 francs)	Cost per insured (in francs)
1913	34.5	0.79
1920	39.1	1.02
1921	37.9	1.0
1922	40.3	0.93
1923	67.3	1.43

(*L'Assurance-maladie dans le Grand-Duché de Luxembourg*)

NORWAY**Legislation**

ACT OF 6 MAY 1915

Benefit Payable on the Death of the Insured

Benefit is payable on the death of the insured, irrespective of the cause of death; it is payable in all cases, except where the insurance institution is liable for the payment of funeral expenses in virtue of other enactments. In the event of a person formerly insured dying subsequent to the date when the right to sickness benefit ceased, funeral benefit is payable provided the deceased had remained incapable of work from that date until his death, that death was due to the illness from which the insured was suffering while in receipt of sickness benefit, and that it occurred within one year of the date when the right to benefit ceased.

Beneficiaries

Funeral benefit, or the fraction thereof used to defray funeral expenses incurred, is paid to the person who undertook the funeral, and any surplus belongs to the husband or wife, or children of the deceased. In the absence of legal heirs of this description any surplus reverts to the fund.

Amount of Benefit

Benefit in all cases consists of a lump sum of 75 kr. (section 27 (1-3)).

Statistics

NUMBER OF DEATHS IN RESPECT OF WHICH BENEFIT WAS PAID

The sickness insurance funds have paid benefit, per 1,000 insured men and women,

	Cases		Cases
1916	in 5.3	1922	in 4.9
1919	„ 6.3	1923	„ 4.6
1920	„ 5.2	1924	„ 4.9
1921	„ 4.9		

(Official Statistics of the Kingdom of Norway.)

COST OF FUNERAL BENEFIT

The total and the average expenditure are indicated in the table below:

TOTAL EXPENDITURE AND EXPENDITURE PER INSURED ON FUNERAL BENEFITS

Year	Total expenditure (in 1,000 crowns)	Average expenditure per insured (in crowns)
1917	115	0.24
1918	266	0.52
1919	174	0.32
1920	146	0.26
1921	136	0.25
1922	143	0.25
1923	135	0.24
1924	146	0.25

(Official Statistics of the Kingdom of Norway.)

POLAND**Legislation**

ACT OF 19 MAY 1920

*Benefit Payable on the Death of the Insured**Conditions under which Benefit is Granted*

No waiting period is required to be completed before an insured person acquires a right to benefit.

Benefit is payable on the death of the insured. The same benefit is granted for the funeral expenses of persons falling ill while members of the fund who died in consequence of the same illness during the half-year following the expiry of the period of sickness benefit without having regained their capacity for work (section 32 (2)).

Beneficiaries

Funeral benefit is payable to the person or persons by whom the funeral expenses have been defrayed, and members of the family do not enjoy any preference or priority in this respect.

Amount of Benefit

Benefit consists of a sum equal to three times the amount of the weekly basic wage, viz. to 21 times the amount of the daily basic wage, since the sickness benefit is payable for seven days in the week (section 32 (1)).

*Benefit Payable in the Event of Death of a Member of the Insured's Family**Nature of the Benefit*

The benefit payable in the event of the death of any of the following members of the family is a statutory benefit (section 33 (e)).

Benefit is payable on the death of any of the following members of the family of a compulsorily insured person living in the same household as himself and entirely dependent on his wages, provided they are neither liable to compulsory insurance nor voluntarily insured: namely, husband or wife, relations in the ascending or descending line, brothers and sisters, foster children and legitimate children: it is also payable to the wife and children of an insured person if they are maintained by him, though not in the same household (section 33 (1)). Benefit consists of one-half of the funeral benefit payable in the event of the death of the insured, viz. to 10½ times his daily basic wage (section 33 (e)).

Statistics**NUMBER OF DEATHS IN RESPECT OF WHICH BENEFIT HAS BEEN PAID****NUMBER OF DEATHS PER 1,000 INSURED PERSONS IN RESPECT
OF WHICH BENEFIT WAS PAID BY 134 FUNDS IN 1924**

Men and women	6.8
Men	7.7
Women	4.6

The cases where funeral benefit was paid by the above 134 funds in 1924 fall into the following groups according to age:

Age group	Men	Women	Men and Women
Per 1,000 in each age group			
Up to 15 years	4.8	3.2	4.2
From 16 to 20	4.3	3.4	4.0
From 21 to 25	4.5	3.0	3.9
From 26 to 30	4.2	3.3	4.0
From 31 to 35	5.0	4.1	4.8
From 36 to 40	6.1	4.5	5.7
From 41 to 45	8.0	4.7	7.3
From 46 to 50	10.4	8.1	9.9
From 51 to 55	12.3	8.6	1.7
From 56 to 60	17.8	20.2	18.2
From 61 to 65	23.1	19.9	22.6
From 66 to 70	31.2	31.2	31.2
From 71 to 75	39.9	18.2	35.9
From 76 to 80	56.8	32.4	51.0
Over 80 years	51.8	62.5	54.3
Age unknown	2.5	1.1	2.3

(Official Statistics of Sickness Funds in 1924.)

AGGREGATE EXPENDITURE AND EXPENDITURE PER INSURED

The total expenditure for 1924 amounted to 1,988,550 zloty, equivalent to an average of 1.11 zloty per insured person.

ROUMANIA

Legislation

ACT OF 25 JANUARY 1912

Benefit Payable on the Death of the Insured

The Act of 1912, which is in force in the territory of the former Kingdom and in Bessarabia, provides that insured persons shall be entitled to funeral benefit in the event of death after a qualifying period of 52 weeks: but the laws in force in Ardeal and in Bukovina do not provide for any qualifying period. Benefit is payable to the insured's survivors, and varies, according to the wage class to which the deceased belonged, from 1,250 to 3,000 lei in the territory of the former Kingdom and in Bessarabia, and from 210 to 1,000 lei in Bukovina. As regards the province of Ardeal, benefit is fixed at 30 times the average daily wage of the deceased.

Statistics

NUMBER OF DEATHS IN RESPECT OF WHICH BENEFIT HAS BEEN PAID

The following information is available with regard to the number of deaths in respect of which funeral benefit has been paid by sickness insurance funds in the territory of the former Kingdom:

NUMBER OF DEATHS IN RESPECT OF WHICH BENEFIT WAS PAID PER 1,000
INSURED PERSONS IN THE TERRITORY OF THE FORMER KINGDOM

Year	Number of deaths per 1,000 insured persons where benefit was paid		
	Men and women	Men	Women
1912-1913	2.2	2.2	2.0
1913-1914	6.7	6.6	7.0
1914-1915	6.0	5.8	8.2
1915-1916	5.8	5.7	7.6
1916-1917	8.7	9.6	8.6
1917-1918	8.7	9.2	3 5
1918-1919	14.5	15.0	10.7
1919-1920	8.2	8.5	5.6
1920-1921	3.8	4.0	1.7
1921-1922	3.7	3.8	2.4
1922-1923	3.8	3.6	5.5
1923 (9 months)	3.4	3.7	2.8
1924	5.4	5.4	5.5
1925	5.2	5.0	6.3

(Buletinul Muncii, 1926.)

COST OF FUNERAL BENEFIT

The following information with regard to the aggregate cost of funeral benefit in the territory of the former Kingdom and in Bukovina is available. As regards the former the expenditure, in 1,000 lei, was as follows:

1912-1913	53	1919-1920	125
1913-1914	132	1920-1921	111
1914-1915	107	1921-1922	165
1915-1916	103	1922-1923	455
1916-1917	77	1923 (9 months)	1,465
1917-1918	49	1924	2,679
1918-1919	86	1925	3,230

As regards Bukovina, the expenditure, in 1,000 lei, was:

1922	59.2	1924	7 84
1923	63.0	1925	—

(Buletinul Muncii, 1926.)

RUSSIA

Legislation

LABOUR CODE OF 15 NOVEMBER 1922

Benefit Payable on the Death of the Insured

No qualifying period is imposed before an insured person becomes entitled to the payment of funeral benefit. Benefit is payable to the person who arranges for the funeral, irrespective of the degree of relationship existing between such person and the deceased, on presentation of the death certificate, and documentary evidence that the expenses of the funeral were in fact defrayed by the applicant. The amount granted by way of benefit is equal to the average cost of a civil funeral, but must not in any case exceed the average monthly earnings current in the locality (section 184).

Benefit Payable on the Death of a Member of the Insured's Family

Benefit is also granted for the burial of a member of the insured person's family who is incapable of work, for whose maintenance he was responsible. Members of the family include husband or wife, children, brothers and sisters under 16, father and mother if incapable of work; in other words, if included in the first three invalidity classes in accordance with the provisions of the Order of 9 December 1921, Collection of Acts No. 79. Benefit amounts to the average monthly earnings current in the locality in the case of relatives over 10 years of age, and to half that amount in other cases.

Statistics**NUMBER OF DEATHS IN RESPECT OF WHICH BENEFIT HAS BEEN PAID**

No data for the country as a whole are available.

As regards Moscow, it is stated that during the first two months of 1923 funeral benefit was paid in respect of 6,682 deaths out of a total of 371,000 insured persons, equivalent to 7.06 per 1,000 insured.

SERB-CROAT-SLOVENE KINGDOM**Legislation**

ACT OF 14 MAY 1922

*Benefit Payable on the Death of the Insured**Conditions under which Benefit is Granted*

Benefit is payable in the event of the death of an insured person, and no qualifying period is imposed. Benefit is also payable in respect of the death of a member who was formerly insured, provided death occurred in consequence of the illness for which he was receiving benefit, and within two years of the cessation of that benefit (section 58).

Beneficiaries

Benefit is paid to the husband or wife, and in default of such, to members of the family. If a third party has made provision for the funeral of the member, the said third party is entitled to the actual expenses of burial, but not more than the amount of funeral benefit (section 52).

Amount of Benefit

Funeral benefit amounts to 30 times the basic wage of the deceased, viz. to 60 dinars for insured persons belonging to the first wage class, and to 1,440 dinars for insured persons belonging to the eighteenth, the highest wage class (section 45 (6)).

Funeral benefit may be increased, in the form of additional benefits, to not more than 45 times the basic wage (section 46 (3)).

Benefit Payable on the Death of a Member of the Insured's Family

The Central Workers' Insurance Institution may, in consequence of a decision of the general meeting and if in possession of the necessary funds, grant funeral benefit in respect of the death of the married or unmarried spouse, legitimate, illegitimate or adopted children, parents, grandparents, grandchildren, brothers, and sisters of the insured. Such benefit may be granted up to the amount of the actual expenses of the burial, provided it does not exceed the amount specified in respect of the insured's death

in section 45 (6) for adults, 200 dinars for children under 14 years of age, 100 dinars for children under 4, and 50 dinars for new-born children (sections 45 (5) and 46 (5)).

Statistics

COST OF FUNERAL BENEFIT

The available information has been embodied in the following table, which shows the aggregate cost of funeral benefit and the cost per insured

AGGREGATE COST AND COST PER INSURED

Year	Total expenditure (in 1,000 dinars)	Expenditure per insured (in dinars)
1922-1923	1,645	3.87
1924	2,422	5.33
1925	2,372	5.02

(Rađmcka Zastita.)

CHAPTER IV

BENEFITS IN KIND

In its early days the main object of social insurance was to provide sick persons incapable of work with cash benefits which were intended to replace the wages lost as a result of sickness. The object may be said to have been to compensate rather than to provide curative treatment for the person stricken with illness. Gradually, however, this conception of the purpose of sickness insurance was replaced by another, rather more social in character, which laid great importance on the provision of medical treatment. Ultimately, the aim of social insurance became the rapid and complete cure of the sick and their return to work.

Benefits in kind granted with a view to hastening the recovery from illness are the most important advantages offered by sickness insurance to the individual and to the community. The great importance attached to these benefits by legislators is shown by the fact that all national compulsory sickness insurance schemes, that of the Irish Free State excepted, agree in granting to insured persons the right to medical treatment and drugs to a varying degree. The sick person ought to call in a doctor when his state of health so requires, and he must be in a position to be able to do so immediately illness affects him, as it is just as important for the community as for the sick person to have medical advice at the beginning of the illness. The sooner a doctor intervenes, the less are the sufferings of the patient and the smaller the loss to the community from his forced abstention from work. Therefore sickness insurance laws do not generally attach any conditions to the grant of medical benefit, and the insured person has the right to it from the moment he is insured and from the first day of illness.

What determines the various services and benefits which the insurance institutions are required to put at the disposal of a sick person with a view to facilitating his recovery ?

In the first place, the insured person is entitled to *medical treatment* which may be administered only by persons duly qualified to attend the sick. Further, it is essential, both in the interests of the insured themselves and in that of the general body of insured persons, that the nature of the treatment should be defined. Again, a limit to the period during which the insured person is entitled to medical assistance may be fixed in accordance with the resources at the disposal of the insurance institution, or because other institutions accept the responsibility for treatment in cases of prolonged illness. Moreover, whatever be the conditions governing the grant of medical treatment by the insurance institutions, the treatment is in itself always what is strictly necessary and appropriate, both as regards duration and character. Nor could it be otherwise, as sickness insurance applied by collective effort must achieve the best social results with a minimum of expense.

The supply of drugs is the inseparable complement of medical treatment. Therefore, under the large majority of national sickness insurance schemes, sick persons entitled to medical treatment from the insurance institutions have also the right to be supplied with drugs, including the supply of the necessary curative appliances of good quality within the limits imposed by those measures of economy which have to be taken into account by all social services.

Hospital treatment may become necessary on account of the nature of the illness, or because the illness necessitates treatment which can only be given in a medical institution. Hospital treatment is given in lieu of medical benefit and the cash sickness benefit, and is the most important alternative benefit. Within the limits of their financial resources, the insurance institutions in many countries are required to provide hospital treatment for insured persons suffering from a contagious disease or a disease requiring treatment which the patient cannot receive in his own home.

Additional benefits may be added to the minimum medical benefit guaranteed by law. This minimum is fixed in such a manner that all insurance institutions, even those working under unfavourable conditions in large districts or where means of communication are scanty, may be able to provide it. But as it is obviously in the general interest to go beyond this minimum when the nature of the disease necessitates it and material resources allow it, the insurance institutions are generally empowered to introduce additional benefits.

In the following pages a survey is made of the measures adopted in connection with the various questions arising out of the introduction of benefits in kind, such as medical assistance treatment, drugs, hospital treatment, and additional benefits in kind. In accordance with the plan of this study, the general summary will be completed by a short description of the legislative measures in the various countries and the statistics of their working.

Two series of questions concerning the study of benefits in kind will be discussed later. In an ever-increasing number of countries, sickness insurance is no longer limited to the insured person. It extends its protection to the family of the insured person by granting them medical and pharmaceutical benefits. This new aspect of social insurance, although of recent origin, is already considered as one of the most important which insurance can assume with a view to the improvement of the health of the working population. We have, therefore, thought it necessary to devote a special Chapter (Chapter VI) to family medical assistance. Furthermore, we have devoted the final Chapter (Chapter VII) of this Part of the study to the examination of questions and measures adopted in connection with the organisation of medical services by the sickness insurance institutions.

§ 1. — Medical Treatment

The authorities responsible for the supply of medical assistance at the expense of the insurance scheme are not free to choose the persons and methods to be employed in curing the sick. They must comply with certain standards concerning the qualifications of the persons who may attend the insured, and concerning the nature of the treatment to be administered. It is therefore necessary to examine these obligations and the period over which they extend.

Before embarking on this examination, however, we desire to make a few remarks on the origin of the right of insured persons to medical treatment. The object of medical aid is, where possible, to cure or at least to alleviate the illness which prevents the insured person from performing his usual work. The doctor should intervene immediately the first symptoms of illness appear. The aim of insurance is therefore to facilitate as far as possible the access of the sick person to the doctor. As has already been stated, the

insured person generally has no conditions to fulfil before becoming entitled to medical assistance, and qualifying and waiting periods, which are usual conditions for the grant of benefits in kind, apply but rarely in connection with medical assistance.

Although almost all the national sickness insurance schemes do not require either a qualifying or a waiting period for persons subject to compulsory insurance, in certain countries a qualifying period is obligatory. In Bulgaria, for example, only those who have contributed to the insurance scheme for a period of at least eight weeks have the right to medical assistance, while in Portugal medical assistance is only granted three months after the payment of the first contribution and provided that the insured person is up to date in his payments. Again, the compulsory insurance schemes which admit optional affiliation frequently insist on a qualifying period for persons who have not previously participated in the scheme. Such a period is compulsory in Latvia (two to six weeks for independent workers and two weeks for temporary workers), in Poland (four to six weeks), in Czechoslovakia (four to eight weeks), while in other States, such as Germany, France (Alsace-Lorraine), and Luxemburg, a qualifying period of six weeks may be introduced by the rules of the fund.

QUALIFICATIONS OF MEDICAL STAFF

The insurance scheme may not entrust the administration of medical treatment to anyone it chooses, but is obliged to call in doctors and surgeons who are duly qualified practitioners in accordance with the provisions of public health legislation. Insured persons thus receive the guarantee that medical treatment granted to them by the insurance institutions will be administered by persons whose knowledge and experience qualify them to give it in accordance with the methods of medical science.

All insurance legislations agree that it is essential to protect the insured persons against the attentions of persons not qualified to treat the sick. Legislative provisions state categorically that medical treatment may be given to the insured person only by fully qualified doctors who are entitled to practice, and the insurance institutions are forbidden to defray the expenses incurred by sick persons calling in persons who are not members of the medical profession.

The above remarks are in no way introductory to a discussion

of the complex questions of the recruitment of medical staff by the insurance institutions. As a matter of fact, even apart from the general rule just mentioned, the law rarely leaves full liberty to the insurance institutions to organise their own medical services. In the interest of the mass of insured persons and sometimes also in the interest of the medical profession, the law establishes definite methods of recruitment and only gives the institution the right to choose between the various methods indicated. Mention will be made later of the question of the recruitment of the medical services.

At the same time a certain amount of attention must here be given to questions which arise in connection with the auxiliary medical staff on the one hand, and doctor and surgeon specialists on the other, while it is also essential to define what class of persons may be entrusted to give dental treatment.

Auxiliary Medical Staff

Persons other than legally recognised medical practitioners who are competent to give medical treatment may, according to law and custom, be allowed to treat the sick, but only on an order, under the supervision and on the responsibility of the doctor concerned, or in urgent cases.

A doctor cannot do without a duly qualified and experienced assistant, and a rational division of labour is generally established between the doctor and his assistant in accordance with professional requirements. Treatment administered by the auxiliary medical staff forms part of the contractual benefits granted by insurance institutions at their own expense. Again, when a sick person has no time to call in the doctor put at his disposal by an institution and when the case is urgent, he may call in the services of another doctor and, failing such, of other persons competent to give the necessary treatment. These latter are, however, required to abstain from all further intervention as soon as the services of a qualified practitioner become necessary, and after first-aid has been given to the sick person. This ruling is intended to meet exceptional cases where any delay is likely to have serious results for the sick person.

But, it should be observed, the intervention of the auxiliary medical staff may be necessary on a much wider scale in the country, where the doctor is not always easily available. In such circumstances the utilisation of the services of the auxiliary medical staff must frequently be considered as a regular element in the organisation of the medical services. Such is the case in certain countries

having compulsory insurance schemes, and, as an example, one may quote German legislation, which authorises sickness funds covering large areas to engage hospital nurses to treat the sick. Nevertheless, only nurses holding State certificates may be so employed, and their intervention is limited to treatment or aid given in conjunction with, or ordered by, a medical practitioner.

Specialists, Physicians, and Surgeons

Should medical assistance organised by the insurance institutions include, and does it actually include, treatment by specialists over and above the services of general practitioners? The question that really arises here is to ascertain whether the sick person is entitled where necessary to demand the services of the best available doctor, or whether he must be content with those of an average general practitioner. The answer to this question varies from country to country, and even in the application of the same system the question is answered differently for industrial centres, country districts, and mountainous regions.

Moreover, very few schemes give a definite ruling on this important point. The meaning of the term "specialist" is still very vague and only in rare cases does the law actually define it. In countries where medical assistance is organised by the sickness insurance scheme in a more or less collective manner, and more especially in those countries where the insured person receives medical assistance mainly through the dispensary of the insurance institution, treatment by a specialist is generally easier to obtain than in those where treatment is provided mainly through an individual medical practitioner.

In one group of systems the rules governing the organisation of medical assistance mention treatment by specialists. This is the case, for example, in Germany, where the institutions in charge of the recruitment of the medical services are required to take into account the possible requirements of the sickness funds in regard to specialists. A similar situation is found in other countries, such as Austria, Czechoslovakia, Hungary, and Poland, which all possess a highly organised insurance scheme. The majority of the other national schemes, while not compelling the insurance institutions to provide the services of specialists, do not exclude them, thus leaving the question to be decided by the funds themselves. Under British legislation the sick person is assured the services of a general practitioner, but there is no guarantee of any skilled treatment

beyond what may reasonably be demanded from a general practitioner. A doctor who considers that the state of health of the insured person requires treatment beyond the competence of an ordinary practitioner has merely to inform the person in question of the steps necessary to obtain the services of a specialist.

Administration of Dental Treatment

The insurance institutions are showing an ever-increasing tendency to grant dental treatment. The general regulations governing the exercise of the dental profession usually determine the qualifications of persons who may be employed by the insurance institution to administer such treatment.

As a rule the treatment of all illness affecting the mouth and jaw may be given only by qualified dental surgeons; the treatment of other disorders of the teeth may be carried out, not only by dental surgeons, but also by dental mechanics, although the latter, in some countries, may treat only with the consent of the patient. Other unqualified persons may intervene only in cases of urgency when the services of a duly qualified dentist are not available.

THE NATURE OF MEDICAL TREATMENT

It is in the interest of the community and in that of the insured person that medical assistance should cure the sick person as rapidly and completely as possible; and while the formulæ by which this obligation is expressed may differ, their meaning is almost identical. The doctor in charge of the case must provide treatment in accordance with the methods of medical science, for the application of which he has been recognised competent by his admission to the medical profession. In addition to diagnosis and general advice, this treatment includes all therapeutic methods, such as are generally applied by the medical profession. In so far as treatment is given at the cost of the insurance institution, the doctor is not allowed to make any difference between the treatment given to the insured person and to his private patients.

Again, sickness insurance is a social service which functions in the general interest. The insured person may not, therefore, claim medical assistance which results in the insurance institutions having to meet heavy charges out of all proportion to the nature and gravity of his illness. However much the legislator may desire to

give the insured person the benefit of the progress of medical science, he can only guarantee them the necessary and appropriate treatment. It is the duty of the doctor, while conscientiously treating a patient to the best of his ability, to avoid all unnecessary and superfluous benefits.

As a general rule, the sick person is required to attend the consulting room or dispensary during the hours of reception fixed by the insurance institution or by the doctor in agreement with the institution, and only persons who cannot move without detriment to their state of health are entitled to claim a domiciliary visit. Apart from these restrictions, which are made in the interests of the whole community of insured persons, the sick person must be treated exactly the same as persons more privileged in worldly goods.

These remarks made, we must now turn our attention to a number of questions which arise concerning the medical intervention required by the state of health of the sick person, such as operations, special curative measures, and dental treatment.

Under all systems of compulsory insurance, the cost of minor operations is borne by the insurance scheme, and such operations are carried out by the doctors in their employment. As regards the major operations which generally require a prolonged stay in a curative establishment, the rules differ from country to country, and even from district to district, according as the cost of hospital treatment is or is not borne by the sick person, whether the hospital is a public or a private institution, and whether or not the demand for hospital treatment emanates from the insurance institution.

Special curative treatment, such as treatment by ultra-violet rays, diathermia, galvanism, and faradization, etc., is granted by the insurance institutions to an ever-greater extent. In this respect it is obvious that the collective organisation of the medical services by the insurance institutions offers much more scope than treatment by an individual practitioner, and that it must be seen, especially in this connection, that insured persons living in the country and those inhabiting industrial centres, while having equal rights, have not equal facilities to obtain the same benefits.

In a very large number of insurance systems dental treatment is an integral part of the medical assistance granted to insured persons. In accordance with the law or special regulations the sickness funds are required to bear the cost of dental treatment, such being the case in Austria, Bulgaria, Chile, Czechoslovakia, France (Alsace-Lorraine), Germany, Hungary, Latvia, Lithuania, Norway, Portugal, Russia, and the Serb-Croat-Slovene Kingdom; in other

countries with compulsory insurance systems the funds voluntarily take steps to organise dental treatment.

Obviously dental treatment at the expense of the insurance institutions can include only the more simple and necessary interventions, and not more costly operations, the cost of which is borne by the patients. The cost of treatment in cases of acute pain and extraction of teeth is always covered by insurance, and, judging by the general policy and frequent decisions taken, the same may be said concerning the preservation of teeth and more especially simple stoppings. The teeth and dental prosthesis necessary for the maintenance of the insured person's health are also covered by insurance, but here certain restrictions and reservations apply to the use of precious metals in the manufacture of apparatus. The British system calls for special attention, as in that country the criterion admitted is relative, and depends on the treatment customarily given by the doctor called in by the insured person. If the doctor is in the habit of providing dental treatment, for example, extraction of teeth in the rural districts, he may not, according to the opinion of the central authorities, refuse the same treatment to insured persons. But apart from cases of this kind, dental treatment is not compulsory, and is merely an additional benefit which may be introduced by insurance institutions within the limit of sums specially earmarked for the purpose.

THE DURATION OF MEDICAL TREATMENT

The period during which the insured person is entitled to medical treatment varies from country to country. Only the British Act which covers all risks of short and long illness, puts no time limit on the right of the insured person to medical treatment, and this is granted as long as it is required. The other national sickness insurance schemes fix the minimum period during which medical treatment may be granted at from 16-52 weeks from the first day on which the sick person requires it. According to the various legislative measures the minimum period is, for all practical purposes, of the same duration as that during which the insured person has the right to cash sickness benefit. When this payment is continued beyond the minimum period, medical treatment is likewise extended. Attention must also be drawn to certain Acts of recent date, such as the Austrian Act on salaried employees' insurance, and the Bulgarian, Czechoslovak, Latvian and Esthonian

Acts, which do not contain any limit for the grant of medical assistance when the insured person continues to work while following his treatment and, consequently, does not receive sickness benefit.

It is obvious that at the expiry of the time limit for the grant of medical benefit an insured person may be very greatly inconvenienced by the cessation of treatment before his complete cure, and it is to avoid this that in certain countries the insured person who has exhausted his right to medical assistance from the sickness insurance funds may receive further treatment from the invalidity insurance funds. In the other countries the duration of medical assistance consequently becomes an element of great importance and determines the exact worth of the insurance system.

Before concluding this Section we must point out that the insurance institutions are in principle compelled to grant medical assistance in kind, that is to say, to put at the disposal of the sick the services of doctors who have agreed to attend the insured persons. There are, however, certain exceptions to this rule, and in Norway, for example, the funds have recently been freed of the obligation to organise medical services, being now only required to refund doctors' fees in accordance with a fixed scale. In all other countries the payment of a pecuniary benefit covering the cost of medical assistance is allowed only with the consent of the supervisory authority and only in special cases, as, for example, when a grant of medical assistance is compromised by the fact that the fund is unable to conclude equitable agreements with a sufficient number of doctors, or when the doctors do not keep to the terms of the contractual agreement.

§ 2. — Provision of Drugs

Curative treatment includes the supply of drugs and curative appliances likely to contribute towards the cure or to mitigate the sufferings of the sick person. The supply of medicaments, as an essential complement to medical treatment, is a right enjoyed by persons insured under the great majority of compulsory sickness insurance schemes. The only exceptions to this general rule are the Irish scheme, which at present provides hardly any benefits in kind, and the Norwegian scheme, which provides the insured person with certain curative appliances but not with pharmaceutical products properly so called.

The general security of the population necessitates that the sale of pharmaceutical products be regulated, and strict legislation on this subject has been introduced in all countries. By this legislation is determined in the first place what products may be supplied to the public only through pharmacies and which of these products may be supplied only on a medical prescription. The exercise of the profession of pharmacist is subject to control by the authorities responsible for public health. The opening of pharmacies to meet the requirements of the population, the preservation and preparation of medicaments, the professional qualifications of pharmacists and their assistants, the official pharmacopœia, the official prices of drugs dispensed, the regulation of hours of business and, more especially, night services in pharmacies, all — to mention only the more important points — call for special and precise regulations. Sickness insurance is bound to fall in with all such regulations and to utilise the organised pharmaceutical services of the country.

It is therefore interesting to ascertain exactly to what extent the insured person is entitled to pharmaceutical aid and under what conditions he may obtain the drugs and appliances he requires.

THE NATURE OF DRUGS PROVIDED

The doctor entrusted with the treatment of the insured person must prescribe the drugs and appliances which he considers necessitated by the patient's state of health.

Notwithstanding all that may be said to the contrary, there are, in no insurance schemes, rigid rules regarding prescribing by medical practitioners. The characteristic independence and the responsibility of the medical profession would not tolerate any such rules. The insured person is entitled to receive the medicines required for his treatment, regardless of their price, hence the obligation of the doctor to prescribe the necessary amount of the appropriate medicines. Taken as a whole, pharmaceutical aid and medical assistance granted to insured persons must be in no way inferior to that supplied by the doctor to his private patients.

But, on the other hand, the rational use of the resources at the disposal of the insurance institutions requires that principles of the strictest economy be observed in the supply of pharmaceutical remedies. There are various methods whereby insurance institutions may secure economy in their medical services and

avoid excessive prescribing. Under certain schemes the doctor may, as a general rule, order only such medicines as are included in the official pharmacopœia or which are mentioned in a special list enumerating the drugs which may be prescribed for insured persons. In the latter case there is, however, no absolute limitation, since the doctor attending the case has only to certify that a certain article is necessary in order to obtain it. More expedient still on account of their elasticity are certain other principles common to a number of schemes and equally efficacious whether they be embodied in the regulations of the medical services or merely advocated in the form of a recommendation.

Prescriptions must be simple. Every effort must be made to avoid complex preparations, to prescribe medicines which can be easily kept, to state the exact quantity of the various ingredients, and to indicate the best way of dispensing them. Among a number of equivalent pharmaceutical products the cheapest should be chosen. As equivalent are considered all products which allow the achievement of the therapeutic aim with the greatest degree of security and with the same rapidity, from which it results that the doctor is in no way forbidden to prescribe a medicine which is more expensive only in appearance, if it gives the possibility of a more rapid and complete cure than do other preparations of a cheaper quality. The same principles are applied when there is a choice to be made between a medicine dispensed by the chemist and a patent medicine, with the result that the insured person is never deprived of a patent medicine of proved worth which cannot advantageously be replaced by other products. It is essential that the doctor should bear in mind that the most efficacious medicine is the cheapest in the long run.

However differently they may be expressed in the provisions of the various schemes, these principles all aim at one and the same object, namely, to guarantee proper medical assistance for insured persons without burdening the insurance funds with unnecessary expense. Nevertheless, the various systems show certain differences according as the provision of drugs properly so called is or is not supplemented by the provision of curative appliances. Attention has already been drawn to the special case of Norway, where sickness insurance limits itself to making the initial provision of spectacles, glasses, and bandages prescribed by the doctor, but takes no responsibility for the cost of pharmaceutical products. In the other insurance schemes the provision of drugs, which is considered an indispensable complement of medical

treatment, includes medicines, that is to say, products the chemical action of which is calculated to prevent, cure or mitigate the illness from which the insured person is suffering, but does not include hygienic or dietetic measures calculated to improve the health or prevent sickness, or simple tonics and nourishing foods, except in special cases and on the strength of the doctor's certificate.

In addition to medicines, the majority of insurance schemes grant certain supplementary benefits in the shape of medical and surgical appliances. Appliances are used during the course of medical treatment to mitigate the suffering of the sick person, to aid in the restoration of his health or to prevent the aggravation of his illness; as a rule, insurance institutions provide bandages, trusses, and other articles essential for the success of the medical treatment. The cost of small articles such as spectacles, crutches, and trusses is generally borne by the insurance scheme. But more costly prosthetic appliances, such as surgical boots, artificial teeth, and supporting appliances are compulsorily granted by sickness insurance only in certain highly-developed schemes, and even there insurance only covers a certain maximum percentage of the cost of such articles, which varies with the nature of the article supplied.

METHODS OF PROVIDING DRUGS

The insured person is entitled to receive free of charge the medicines and therapeutic appliances prescribed by the doctor, and the insurance institution may not limit itself to refunding a part or the whole of the expenses incurred, as it is, in principle, bound to give benefits in kind.

As we have already seen, the insurance institution is, in the interests of the security of the insured person, in no way exempted from the precautions imposed on pharmacies by the legislation, and is obliged to make use of the general pharmaceutical services of the country.

The arrangements between the sickness insurance institutions and the pharmaceutical services for the supply of prescribed medicines to the insured person are regulated by the law or by a special agreement concluded between an insurance institution and the chemists.

In certain countries as, for example, Austria, Czechoslovakia, Hungary, and Poland, every pharmacy may be utilised by the insurance institutions, as it is required in accordance with certain

legal provisions to supply at their expense the medicines prescribed by the doctor of a sickness fund. The institutions are not required to pay the usual fixed prices but benefit from reduced rates (*taxa pauperum*), which are fixed from time to time by the supervisory authority and which vary with the importance of the pharmacy, small pharmacies giving less reductions than those imposed on larger establishments. In order to benefit by these reductions the institutions are required to pay their accounts at certain fixed periods and, where necessary, to grant advances to the pharmacies.

In other countries the relations between insurance institutions and pharmacies are determined by the acceptance by groups of pharmacies or by single shops of a model agreement drawn up by the authorities (e.g. the panel chemists in Great Britain), or by the acceptance of special agreements offered them by the sickness funds, as in Germany. Insured persons may purchase drugs only in pharmacies which have entered into an agreement with the insurance institutions and these may refuse, cases of urgency excepted, to refund the cost of drugs purchased in other pharmacies. Under these systems also the insurance institutions are as a rule entitled to reduced prices.

Drugs supplied at the expense of the insurance institutions must be dispensed in a simple and rational manner, and as economically as possible without prejudice to the insured person.

Pharmaceutical products and therapeutic appliances of which the sale is public and not exclusively reserved to pharmacies may be supplied by the institutions themselves or on their account by druggists or stores.

In certain countries as, for example, Austria and Czechoslovakia, the sickness funds or federations of sickness funds are empowered to open their own pharmacies which are, however, subject to the general regulations governing the pharmaceutical profession and which may supply only the members of the funds concerned.

§ 3.— Hospital Treatment and Nursing

The legislator who determines the rights of the insured person to benefits in kind must of necessity take into account not only the financial difficulties but also the material impossibility in which an insurance fund may find itself as regards the supply at a given moment of the requisite benefits in kind. It is for this reason.

that the minimum benefits guaranteed by law, and which may have to be supplied equally by a rural fund covering a very large area or by a fund in an industrial centre, do not represent the optimum benefits which the development of medical science and facilities would appear to offer.

At the same time insurance institutions in possession of sufficient means to allow them to grant benefits in excess of the strict minimum required by law may, and in certain circumstances must, provide benefits more in keeping with the circumstances in question than with the legal minimum. Thus, the medical treatment ordinarily given in the doctor's consulting room or in a dispensary may be replaced by treatment in a hospital or a curative establishment, or, again, the sick person may receive nursing care in his home.

HOSPITAL TREATMENT

The substitution of treatment and maintenance in a curative establishment for medical treatment and sickness benefit is provided for in a large number of compulsory sickness insurance schemes including those in force in Austria, Czechoslovakia, Bulgaria, France (Alsace-Lorraine), Hungary, Germany, Latvia, Lithuania, Luxemburg, Norway, Poland, Roumania, Russia, and the Serb-Croat-Slovene Kingdom.

The extent of hospital treatment afforded by the insurance institutions depends largely on the number and equipment of the public and private curative establishments in which the institutions are entitled to place patients. Public and sometimes private hospitals agree to reserve a certain proportion or a certain number of beds on behalf of the insurance institutions in their district and grant special terms to patients sent by the institutions. The insurance institutions are able to afford greater facilities for hospital treatment when they possess their own private curative establishments, and it is to be noted that the large territorial funds and federations of funds have a great advantage in this respect, especially when they are administratively connected or collaborate with the invalidity insurance institutions.

Although not a compulsory benefit, hospital treatment is more than an additional benefit. As a rule, the insurance institution is not obliged (with the exception of the salaried employees' insurance scheme in Austria) to provide hospital treatment, but it must do so as far as it is able in cases of contagious diseases or

when the treatment required cannot be given elsewhere than in a curative establishment, or if the state of health or conduct of the sick person necessitates constant supervision.

In addition to the above-mentioned cases, hospital treatment may be provided if the competent organs of the insurance institutions consider it to be necessary, but only with the consent of the sick person when such has his own household or is living with his family.

The cost of transport incurred by removal to hospital is borne by the insurance institution.

In the choice of hospital, the insurance institutions are not bound to confine themselves to hospitals situated in the district inhabited by the sick person, and must as far as possible take into account the sick person's preference.

When treatment in hospital includes the complete maintenance of the sick person, the payment of sickness benefit is usually suspended. A part of the sickness benefit is however paid to the family of the person in hospital to help towards their maintenance: according to certain laws the person in hospital receives or may receive an allowance to provide himself with comforts.

HOME NURSING

Another form of special assistance, which is, however, granted more rarely, is the treatment of the sick person in his own home by the doctor assisted by a nurse. This is granted only when treatment in hospital, although desirable, is not practicable and when there are special reasons for leaving the sick person with his family. Such treatment is provided for in Austria, France (Alsace-Lorraine), Germany, Japan, and Luxemburg; a reduction of sickness benefit may be provided for in the rules in cases where a nurse is supplied.

§ 4. — Additional Benefits

A large number of national laws authorise insurance institutions with adequate resources to grant additional benefits in addition to the legal minimum medical and pharmaceutical benefits. A very fertile field of action is thus opened up for those institutions whose finances have been wisely managed.

The conditions regulating the introduction of additional benefits in kind are similar to those governing the grant of additional cash benefits. In Great Britain and the Irish Free State the sum necessary to finance the payment of additional benefits may be provided only from the surplus earmarked for the purpose by the Government actuary after his periodical valuation of the assets and obligations of approved societies. Most of the other national schemes authorising the introduction of additional benefits confine themselves to stipulating that the payment of such benefits must not lead the insurance institutions to increase the insurance contributions beyond the limits laid down by the law.

The nature and the scope of the additional benefits which may be introduced depends partly on the extent of the legal benefits and on the place assigned to sickness insurance in the general measures taken in the interests of public health, and partly on the financial resources available for insurance purposes over and above the minimum sum absorbed by the regular benefits. In spite of the great divergences existing in this connection between the various insurance schemes, it has been possible to classify the several forms of additional benefits provided for in the different countries, as follows:

- (1) The insurance institution may be empowered to prolong the period during which the insured person is entitled to medical and pharmaceutical benefits. Such prolongations are admitted in Austria, Germany, Luxemburg, Poland, and the Serb-Croat-Slovene Kingdom.
- (2) Provision may be made for the sick who require it to be treated in special curative establishments and convalescent homes, or for a stay in the country at the expense of the insurance institutions. Benefits of this nature are authorised in Czechoslovakia, France (Alsace-Lorraine), Germany, Great Britain, Hungary, Luxemburg, Poland, and Portugal.
- (3) Sick persons may be provided with costly artificial limbs and appliances to which on account of their cost they are not entitled as statutory benefits. The provision of artificial limbs is authorised in Czechoslovakia, France (Alsace-Lorraine), Germany, Great Britain, Hungary, and Luxemburg.
- (4) In like manner, special treatment not comprised in the medical treatment guaranteed by law, such as, in certain countries, optical and dental treatment, may be granted as additional benefit.

§ 5. — National Laws and Statistics

In the following paragraphs have been summarised, country by country, the main legal provisions and regulations concerning the benefits in kind granted in the event of the sickness of the insured person. The summary is wherever possible followed by a brief indication, based on official documents, of the statistics relating to these benefits in the various countries.

The analysis of national laws covers among other things the conditions for the grant of benefits, legal benefits and additional benefits; the statistics, taken from official sources, show the total cost per insured person of the various types of benefits in kind and the amount of additional benefits in kind.

AUSTRIA

LEGISLATION

*Act of 30 March 1888; New Text Promulgated by
the Order of 30 November 1922*

Insured persons are entitled to medical benefit including medical treatment, drugs, and other therapeutical requisites.

Conditions under which Benefits are Granted

The right to medical benefit runs as from the first day of the illness and of the entry of the insured person into the fund. There is no qualifying or waiting period.

Medical benefit is granted for the whole duration of the illness for a maximum of 26 weeks if the patient is not cured sooner. Nevertheless, if the insured person has been insured for 30 consecutive weeks at least before the illness, he is entitled to medical assistance, together with sickness benefit, for 52 weeks at most (section 6, No 2).

Legal Benefits

The fund determines to what extent free medical benefit shall be granted to insured persons. Medical treatment includes also dental treatment, and in particular, the stopping of teeth. Pharmaceutical assistance includes in theory all drugs and special medicines which may be granted at the expense of the insurance institution.

The funds have for a long time been doing their utmost to secure the use of simple and economical drugs. If the doctors of the funds are compelled to impose certain restrictions as compared with the drugs which they prescribe to their private clients, such restrictions are only introduced with the object of sparing the general body of insured persons unnecessary expenditure. With this object in view, it is prescribed:

- that when there is a choice of several medicines, use should be made of that which, while it has the same composition and the same therapeutic action, occasions less expenditure,
- that drugs should be prescribed in such a form as will involve less expenditure on preparation, always provided that this form does not involve any particular inconvenience or disadvantage for the patient;
- that drugs should be supplied in as simple a container as possible (see report of the Vienna Fund for 1924).

The Union of Sickness Funds of Vienna and Lower Austria, the duty of which it is to provide medical benefit for more than 400,000 insured persons, grant all necessary or useful drugs without consideration of price. Insured persons even receive costly artificial limbs. The apparatus become the private property of insured persons with the exception of especially costly apparatus for temporary use which may be utilised by other patients.

In accordance with the legal theory laid down by the Administrative Court, by therapeutical requisites is understood any apparatus granted with the object of allowing the insured person to resume his occupation. It is therefore that artificial teeth and dentures are supplied on medical prescription with a view to the recovery by the patient of his earning capacity or the cure of gastric diseases.

The supply of drugs on behalf of the sickness fund is regulated by the Decree of 10 September 1906:

When making prescriptions doctors must, unless special authorisation is given, confine themselves to drugs and bandages which will be found in the *Pharmacopœia* (section 2, par. 2). The prescription of other drugs or bandages are only allowed as an exceptional measure and in cases in which the doctor considers them to be indispensable. In order to prove that his choice has been made after careful reflection he must add the word "necessary" (section 3).

In treating a patient the doctor must prescribe only the drugs and bandages which he considers necessary (section 6, par. 1).

Prescriptions must be as simple and as cheap as possible.

When two or more drugs are equally efficacious from the medical point of view the cheaper drug must be prescribed. The same rule applies as regards the form in which the drug is made up (section 6, par. 2).

Free medical treatment, drugs and sickness benefit may be replaced by sending the patient to hospital with free attendance in the second class. In the case of a person living with a wife or husband or some other member of the family the consent of the patient is necessary for removal to a hospital, unless such removal is necessitated by the very nature of the disease. In all other cases the fund may order the insured patient to be removed to a hospital without his consent.

In addition to hospital treatment and free maintenance the patient is entitled to transport to the hospital (section 8, pars 1 and 2).

If the patient under treatment in a hospital has relations who until his entry into the hospital lived upon his earnings the sickness fund must pay them at least half the sickness benefit.

With his consent a skilled nursing attendant may be placed at the disposal of the patient. The cost of this may be deducted from the sickness benefit allowance up to 50 per cent. (section 9, No. 6.)

As a form of additional benefit the rules may provide for the extension up to one year and a half (section 9, No. 4) of the period during which free medical treatment is supplied.

Special sums may be set aside for purposes in connection with sickness insurance. They may in particular be earmarked for the grant of optional benefits and for special arrangements for the care of the sick or convalescents and also for preventive measures against national plagues, such as tuberculosis, alcoholism, and venereal disease, together with the encouragement of any efforts in this direction (section 9b, pars. 1 and 2).

Restrictions of statutory benefits may be made by the rules, and in particular.

it may be provided that in the case of insured persons living outside the area of a given fund medical benefit may be replaced by a supplementary sickness benefit (section 9c, No. 1);

in the case of certain drugs and therapeutical requisites maximum limits may be laid down with the object of reducing the expenses of the fund in this connection (section 9c, par. 2).

STATISTICS

The following table shows the total cost of various types of benefits in kind and the proportion of such cost to the total cost of all benefits granted

TOTAL COST OF VARIOUS TYPES OF BENEFITS IN KIND AND PROPORTION OF SUCH COST TO TOTAL COST OF ALL BENEFITS ¹

(a) Expenses for expenditure on benefits in kind in millions of crowns for 1919 and millions of schillings for 1925 (b) Percentage of the total cost of benefits

Year	Medical attendance		Pharmaceutical assistance		Treatment in hospital		Total	
	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
1919	14.9	20.3	5.2	7.1	5.8	7.9	25.9	35.3
1925	19.99	23.3	10.58	12.3	11.1	12.9	41.67	48.5

¹ Official Statistics of the Ministry of Social Administration.

BULGARIA

LEGISLATION

Act of 6 March 1924

Sickness insurance includes medical treatment at the dispensaries or at home, hospital treatment, surgical assistance, the supply of medicines, curative and surgical appliances and, where necessary, treatment in bathing establishments and residence in convalescent homes and sanatoria (Article 127 of the Regulations).

Conditions under which Benefits are Granted

Every insured person who has contributed for at least eight weeks to the social insurance fund is entitled to benefits in kind, provided the sickness shows itself after he has become subject to insurance (Article 126, par. 1, of the Regulations).

The insured loses his right to treatment at the expense of the fund if he was not a member of the fund for the week in which he fell sick, unless such default of membership can be attributed to proved unemployment lasting not more than eight weeks from the date when it began, or to other reasons recognised as sufficient by the governing body of the fund (section 18, par. 3, of the Act).

In case of sickness arising after becoming subject to insurance an insured person receives medical attendance at the expense of the fund for nine months in the year provided he has paid his membership contributions for eight consecutive weeks. The period of nine months commences on the day when the sickness shows itself. If treatment takes place at several periods during the year the total must not exceed the period of nine months provided for (section 18, par. 1, of the Act and Article 128 of the Regulations).

If, however, an insured person is sick but remains at work, he receives treatment as long as the same is necessary (Article 128, par. 2, of the Regulations).

If the insured person fails to recover within nine months, he loses his right to benefits in kind but receives pecuniary benefit equal to 75 times the amount of the daily sickness benefit (Article 129 of the Regulations).

The right to benefits in kind is extinguished if the insured fails to conform to the doctor's orders or if he undergoes imprisonment in pursuance of a sentence having the force of a final conviction.

The right to benefits in kind is also lost if the insured lends his insurance book to other persons who use it for the purpose of obtaining gratuitous treatment (Article 131 of the Regulations).

Legal Benefits

Medical treatment takes place either at a dispensary or at the patient's home. The doctor must observe strict rules during treatment, attending the patient for preference in his consulting room where the condition of the patient permits. Attendance at home is only allowed in serious cases and where it is impossible to convey the patient to a hospital (Article 135 of the Regulations). In case of an unnecessary call to the doctor to attend at the patient's home, the latter must pay the difference between the scale for visits to the home and visits at the consulting room (Article 135 of the Regulations).

If the nature of the disease and the circumstances of the case require, the doctor in attendance may send the patient to a specialist (Article 136 of the Regulations).

Dental treatment at the expense of the fund includes treatment for directly relieving diseases of the teeth, extractions and treatment of the gums. Dental prosthesis at the expense of the fund is limited to stopping and fixing of teeth or plates where the condition of the patient requires the same. Where, however, the disease of the teeth has an occupational origin, stopping and fixing of teeth and plates is authorised in any case (Article 138 of the Regulations).

Workers are entitled to the medical requisites which their condition necessitates (section 18, par. 2, of the Act).

Supply of medicine is only allowed where the same is necessary. Where practical advice is sufficient or where the insured is capable of preparing the necessary medicines himself, the doctor does not furnish a prescription (Article 142 of the Regulations).

Medicines are prescribed in accordance with a list of medicines and health appliances fixed by regulations. Such list may be supplemented as required by the competent Minister (Article 144 of the Regulations).

Medicines must be prescribed in the simplest form having regard to the age of the insured. In the prescribing and supply of medicines strict economy must be observed (Article 145 of the Regulations).

Where no definite diagnosis has been made medicines must not be prescribed for more than three days. When the diagnosis is established the doctor may prescribe medicines for a period not exceeding seven days. Exceptions are only allowed in cases of chronic diseases (Article 146, par. 1, of the Regulations).

It is not permitted to prescribe pomades, or cosmetic powders or liquids. The same is the case with syringes, except in the case of accidents, for which it is permitted to prescribe droppers, ice bags, spectacles, etc. (Article 147 of the Regulations).

It is also not permitted to prescribe fresh medicine if that already prescribed has not yet been used. If the insured fails to use the medicine prescribed without authorisation by the doctor, he is deprived of the right to attendance from the fund for a period of six months (Article 148 of the Regulations).

If the condition of the patient requires medicines not included in the official list, the doctor is authorised to prescribe them subject to giving the reasons for requiring the same in the prescription itself (Article 150 of the Regulations).

Treatment in hospital is allowed in serious cases, including cases of infectious and venereal diseases. The doctor is not required to obtain any permission for sending a patient to a hospital. If the hospital is situated in another town he must notify the competent factory inspector (Article 145, par. 1, of the Regulations).

STATISTICS

See page 216.

CHILE

Act of 8 September 1924

The Act provides for benefits comprising medical attendance and therapeutic requisites and, where necessary, hospital treatment.

Conditions under which Benefits are Granted

Benefits are granted to insured persons who have completed a qualifying period of seven months computed from the payment of the first contribution (section 22)

The maximum legal duration of benefits in kind is 26 weeks.

Legal Benefits

The fund is required to furnish medical attendance and the provision of all therapeutic requisites necessary for the cure of the patient.

The medical practitioner may order the sick person to be placed in a hospital on account of the impossibility of giving proper care in his own home, particularly in the case of infectious diseases or those that require special trained attendance.

Medical attendance is provided by a competent staff under a contract with the fund. Insured persons have the right to select their medical practitioner from those at the disposal of the fund and to be reimbursed for the expenses incurred for attendance by specialists who have been called in with the authorisation of the governing body of the fund (section 15, par. a).

Additional Benefits

The funds may extend the period of medical attendance up to one year in special cases (section 15, par. a).

CZECHOSLOVAKIA**LEGISLATION***Act of 9 October 1924*

The sickness insurance institution is required to grant free medical treatment together with the necessary drugs and other therapeutic aids.

Conditions under which Benefits are Granted

There is no qualifying or waiting period before a member becomes entitled to medical attendance. This is granted as from the beginning of the illness, i.e. as from the day on which the illness was notified to the sickness insurance institution, and lasts as long as the illness lasts up to a maximum period of one year from the date on which the incapacity to work began to run (section 95, subsection 1 (1)). The conclusion may be drawn that the duration of medical attendance is limited only in cases where the illness involves incapacity to work, whereas in any other case the patient preserves his right to medical attendance for an unlimited period "so long as the illness lasts". The patient is entitled to medical attendance even when he is outside the area of his insurance institution. The Act compels the local insurance institution to grant medical attendance equally to an insured person of another insurance institution if he is within its area, either in case of absolute necessity or at the request of the sickness insurance institution to which the person concerned belongs (section 103).

Legal Benefits

Medical treatment includes the services of a qualified doctor as well as any necessary surgical assistance. The insured person is not entitled to treatment by any given doctor nor by any specific medical process. Drugs must be such as to prevent, cure or alleviate suffering. Therapeutic aid must be of such a kind as, after the end of the illness (which does not necessarily coincide with complete cure), to diminish or render bearable the consequences of the illness. It is for the insurance institution to determine on local advice what are the necessary drugs and therapeutic aids.

When drawing up the prescription, the doctor must take account of the general rules governing prescriptions made to the order of public funds. Pharmacies are compelled, when dispensing drugs and therapeutic aids for the account of public corporations, to observe the rules drawn up for the purpose. The Decree of 10 December 1906 (*Bulletin of Laws*, No. 235) lays down the chief

principles which must be observed in the drawing up of prescriptions and the dispensing of drugs and therapeutic aids for the account of sickness funds and public corporations and funds. Section 6 of the Decree provides that the doctor must prescribe only the necessary pharmaceutical products. The prescription must be simple and cheap as regards the methods prescribed and the form of the prescription. When two pharmaceutical products serve the same therapeutic end under the same conditions, the cheaper of the two products must be supplied. This rule also applies to the form of the products supplied.

Treatment in hospital may be granted in lieu of medical attendance in its ordinary form.

The sickness insurance institution may grant treatment in hospital, but it is in this case compelled to transport the patient to the hospital at its own cost (section 145, subsection 1).

In order to be admitted to a hospital, the patient must give his consent. The patient under age but over 17 years of age may give his consent personally, but for a minor under 17 years of age the consent is given by the head of the family.

Consent is not necessary:

- (a) if the patient does not live with members of his family;
- (b) if the disease requires treatment or attendance which cannot be given in the patient's family;
- (c) if the nature of the disease requires it; in particular, in the event of a contagious disease;
- (d) if the patient has disobeyed the rules for the conduct of patients or the instructions of the doctor attending him;
- (e) if the state or conduct of the patient demands constant supervision (section 145, subsection 3).

It is for the sickness insurance institution to decide whether hospital treatment should be granted and to what sanatorium the patient should be admitted.

The Central Insurance Institution may in a given case at any moment order the sickness insurance institution to treat a patient in a hospital. Nevertheless, the Central Institution is compelled to pay the sickness insurance institution the additional charges resulting from such a decision (section 146). Apart from these cases the sickness insurance institution is not compelled to treat patients in a hospital, and patients may not take an action for this purpose before an arbitration court. In practice, however, the patient can secure admission to a hospital on his own initiative if his state of health admits it, thus the insurance institution concerned is required in all circumstances to bear the cost of maintaining a patient in a public hospital and, in event of it being impossible to refuse admission to the patient because of his state of health, also the cost of maintaining him in a private hospital.

As regards cash benefits granted during the hospital treatment of compulsorily insured persons, a distinction must be made between the first four weeks and the subsequent period.

Until the expiry of the twenty-eighth day (that is to say, during the period in which the insurance institution is required to pay the public hospital the total cost of the maintenance of the patient)

- (a) the members of the insured person's family receive half the sickness benefit and the insured person himself is not entitled to any cash benefit;
- (b) the insured person who has no family dependent on him is not entitled to sickness benefit, even in the event of the cost of his maintenance in a public hospital being less than the sickness benefit.

As from the twenty-ninth day of treatment in a hospital:

- (a) the members of the patient's family receive the total amount of the sickness benefit (the public hospital receives no reimbursement for maintenance);
- (b) the insured person who has no family dependent on him receives half the sickness benefit, the other half being given to the hospital (sections 148 and 149).

When a patient is treated at home, he may be given the services of skilled nurses, the cost of which may be covered by a reduction of the sickness benefit by one-half at most (section 152).

Additional Benefits

Subject to the condition that the amount of the sickness insurance contribution should not, generally speaking, exceed 5 per cent. of the average daily wage, the rules of a sickness insurance institution may provide

- that the insurance institution should, for purposes of convalescence, during a maximum period of one year after medical assistance has come to an end, grant the patient treatment in a convalescent home or sanatorium and supply him with drugs and therapeutic aids;
- that the insurance institution should supply apparatus for the correction of deformities and mutilations (section 105, subsection 1, (g) and (h))

The Central Insurance Institution may require the sickness insurance institutions in given areas to grant the additional benefits referred to above or at least some of them. In such cases it must pay half the resultant cost (section 105, subsection 2).

The Central Insurance Institution may, either *ex officio*, or at the request of the person concerned or of the competent sickness insurance institution, substitute for benefits a curative treatment, the object of which is to restore to the patient his earning capacity and to prevent or retard the invalidity which might result from his illness. For this purpose the Central Institution may

- (a) place the patient at its own cost in a hospital, sanatorium, or other establishment, suitable for his cure, or in a convalescent home;
- (b) at the end of the cure educate the patient at its own cost in his old or a new occupation (section 154).

The Central Insurance Institution may authorise a sickness insurance institution which finds it impossible to guarantee the normal working of its medical service to grant patients during this emergency period a supplementary sickness benefit instead of medical treatment. The amount of this benefit is fixed by the Central Institution (section 144).

STATISTICS

The provisions of the Act of 1888, which was in force until 1 July 1926, are not appreciably different from the provisions analysed above, so that there is a present interest in considering the statistics of benefits in kind granted under the old legislation.

The following tables¹ show the average expenditure per member for the various types of benefits in kind and the percentage represented by benefits in kind of the total cost of benefits.

AVERAGE EXPENDITURE PER INSURED PERSON FOR VARIOUS TYPES OF BENEFITS IN KIND

(1) *Bohemia, Moravia, and Silesia*

(a) Average expenditure per member in crowns (b) Proportion of benefits in kind to the total cost of benefits

Year	Medical treatment		Drugs		Hospital treatment		Total	
	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
1921	41.72	13.37	27.74	8.89	22.91	7.34	92.37	29.60
1922	49.26	12.74	33.84	8.75	26.06	6.74	109.16	28.23
1923	50.22	15.00	30.57	9.13	26.46	7.91	107.25	32.04
1924	52.60	16.90	32.00	10.30	26.00	8.50	111.10	35.70
1925								

¹ Statistics of sickness insurance prepared by the Ministry of Social Welfare.

(2) *Slovakia and Sub-Carpathian Russia*

(a) Average expenditure per member in crowns (b) Proportion of benefits in kind to the total cost of benefits

Year	Medical treatment		Drugs		Hospital treatment		Total	
	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
1921	24 30	10.00	35.85	14 70	26 41	10 80	86 56	35 50
1922	30 52	9 79	38.92	12 49	37 39	12 00	106 83	34 28
1923	28 02	10 58	28 53	10 77	33 00	12 45	89.55	33 80
1924	27 50	10 30	27.20	10 20	31 40	11 80	86 60	32 40

ESTHONIA

LEGISLATION

Act of 23 June 1912

The benefits in kind provided by the Act are, first and in case of sudden illness, treatment at a dispensary, hospital treatment including maintenance, a free supply of medicines, dressings and other necessary therapeutic appliances.

Conditions under which Benefits are Granted

Medical attendance is granted where the sickness does not involve incapacity for work, so long as the patient is a member of the fund. In other cases such attendance is allowed for a maximum period of 26 weeks computed from the first day of sickness, but in no case for more than 36 weeks in a year (section 301)

Legal Benefits

Medical attendance is given at the expense of the employer. Sickness funds may, however, themselves organise benefits in kind. If they do so, the employer must pay them supplementary contributions not exceeding 2 per cent of the wages earned by the insured (section 304)

Medicines are provided on the prescription of the doctor in attendance.

FRANCE (Alsace-Lorraine)

LEGISLATION

Social Insurance Code of 19 July 1911

Insured persons are entitled to medical treatment and drugs

Conditions of Benefit

No qualifying or waiting period is prescribed for persons insured under the compulsory provisions. Benefits in kind are granted from the commencement of the sickness and cease at the latest at the expiration of the twenty-sixth week following such commencement. If, however, cash benefit is continued after the expiration of the twenty-sixth week after the commencement of the sickness, the right to medical attendance expires at the same time as the right to sickness benefit (sections 182 and 183).

Legal Benefits

Medical attendance includes medical attendance and medicines and the supply of spectacles, trusses and other remedies of less importance. The fund may substitute hospital treatment for medical attendance and cash benefit if the patient has a home of his own or lives with his family. His consent is necessary except in the following cases:

- (1) If the nature of the disease requires treatment and attention which cannot be given in the patient's home

- (2) If the disease is contagious.
- (3) If the patient has on several occasions failed to observe the regulations relating to sick persons and the orders of the doctor in attendance.
- (4) If the condition or the behaviour of the patient require continual supervision (section 184)

In addition the Superior Office may make an order allowing the fund to treat the patient in a hospital even where the above-mentioned conditions do not exist (section 370)

Where a patient treated in a hospital has a family which he has previously wholly or partly maintained from his wages, the members of such family are allowed a family allowance. Such benefit must be paid directly to the members of the family (section 186).

Home nursing may be accorded to the insured person with his consent. In such case he receives attendance and treatment by nurses, particularly where hospital treatment is desirable but cannot be obtained or where there are serious reasons for leaving the patient in his home or with his family. The fund is authorised to provide by its regulation for a reduction not exceeding one-fourth in sickness benefit (section 185)

Additional Benefits

The regulations may, with the consent of the Superior Insurance Office, fix a maximum for therapeutic appliances of less importance and provide that the fund may grant an additional benefit up to such maximum for the acquisition of the more important therapeutic appliances

The regulations may also allow during medical treatment assistance other than therapeutic appliances of less importance, including the supply of food to the patient.

The regulations may provide for a convalescent treatment, including admission of the insured into a convalescent home for one year from the expiration of sickness benefit and for the supply, at the expiration of the period of medical treatment, of the necessary means for preventing deformity or mutilation with a view to maintaining the working capacity of the insured.

STATISTICS

The following table gives the total cost and the average cost of benefits in kind.

TOTAL COST AND AVERAGE COST PER INSURED PERSON OF
BENEFITS IN KIND

Year	Total cost of benefits in kind (in thousands of francs)	Average cost per insured person (in francs)	Percentage of total cost of benefits
1919	11.466	33 59	43 20
1920	18.255	88 41	53 58
1921	24.431	62 49	46 39
1922	29,744	71 95	47 40
1923	34,700	79.03	50.97

The distribution of expenditure over the various forms of benefit in kind appears from the following table

DETAILS OF BENEFIT IN KIND

(a) Average expense per insured person in francs in kind (b) Percentage of cost of benefits in kind

Year	Medical and dental treatment		Drugs		Hospital treatment and home nursing	
	(a)	(b)	(a)	(b)	(a)	(b)
1919	13.14	39 14	10 29	30 63	9 36	27 86
1920	18 99	40 09	15 20	32 08	11 93	25 18
1921	24 68	34 49	18 94	30 30	17 05	27 29
1922	31 32	43 53	19 86	27 60	18 63	25 89
1923	31.11	43 16	21.48	27 18	21.28	26.92

Sickness benefit is compulsorily payable for a maximum of 26 weeks. The period of benefit may, however, be extended beyond 26 weeks by the regulations

STATISTICS OF FUNDS GRANTING BENEFIT BEYOND 26 WEEKS

Year	Total number of funds	Number of funds granting		
		total benefit	reduced benefit	medical attendance only
1919	264	22	32	6
1920	257	11	41	8
1921	252	16	44	7
1922	247	10	42	6
1923	247	19	35	10

GERMANY

LEGISLATION

Notification of the New Text of the Federal Insurance Code of 15 December 1924

Medical benefit granted to insured persons includes medical treatment and drugs together with glasses, hernia bandages and other minor appliances. (section 182, No 1).

Conditions under which Benefits are Granted

The right to statutory benefits begins when the compulsorily insured person joins an insurance institution (section 206); benefits are due even in the case of insured persons who are ill at the moment of their becoming members. On the other hand, a voluntarily insured person who is attacked by sickness at the moment of his admission is not entitled as regards the illness in question to any benefits from the fund (section 310 par 2). Moreover, in the case of voluntarily insured persons the rules of the funds may provide for a preliminary qualifying period of six weeks at most (section 207).

The rules may also provide both for compulsorily and voluntarily insured persons that the right to additional benefits should begin only at the expiry of a qualifying period of six months at most from the beginning of membership. This period is, however, not applicable to members who during the previous twelve months have already been entitled for at least six months to additional benefits from a fund established under the Federal Insurance Code or from the Federal Miners' Benefit Society (section 208)

Medical benefit is due as from the beginning of the illness without any waiting period (section 182, No 1).

Sickness benefit expires at latest at the termination of the twenty-sixth week following the beginning of the illness or, if the sickness relief is granted only as from a later date, on the expiry of the twenty-sixth week following such date. If sickness benefit is continued after the expiry of the twenty-sixth week, the right to medical benefit expires at the same time as the right to sickness benefit. The fund must in principle grant benefits within its own area only. It follows that the insured person who falls sick and goes outside the area of his fund without the consent of the fund is not entitled to the benefits placed at the disposal of sick persons by the fund and, generally speaking, loses his right to medical benefit. Nevertheless, an insured person who is prevented by an emergency from profiting by the assistance placed at his disposal by the fund, as, for example, in the case of a virulent disease which attacks him during a stay outside the area of the fund, may claim benefits in the district where he is temporarily staying.

Legal Benefits

Benefits must be granted in the form prescribed by the Act, and the fund may not at its discretion substitute pecuniary relief for benefits in kind or vice versa.

Medical benefit must be given in kind, i.e. the fund must take steps to secure a medical service. It may not confine itself to repaying insured persons their medical expenses but is bound to put the services of a doctor at the disposal of the insured persons and for this purpose to conclude agreements with medical associations or with doctors (section 368, par. 1).

The fund must supply only necessary assistance, but such assistance must be given without reservation. In consequence it is not necessary to ask for preliminary authority in every case from the committee of the fund.

Dental treatment is included in medical benefit. It must be given by doctors or by dental surgeons. If the insured person is attended by a dental surgeon, however, he cannot demand payment of the necessary cost if the fund has offered him the service of a dentist who is qualified to treat insured persons and if the sick person has refused the services of the dentist without valid reason.

Medical benefit also includes the services of a specialist whenever necessary.

Travelling expenses necessitated by recourse to the doctor, in particular the expenses of transporting the sick person to the doctor and vice versa, are included in medical benefit. The same is the case with the expenses of transporting an insured person who falls ill at the place of work to his own home, especially when medical attention is a matter of urgency. Insured persons who, with the consent of the fund, consult a specialist away from their home may claim travelling expenses and even maintenance allowance.

Mechanical treatment and treatment by Röntgen rays are included in medical benefit. The same is true of diathermal and other special treatments (see the general principles laid down by the Federal Committee of Doctors and Sick Funds, 15 May 1925, on the employment of electro-physical curative methods).

Sick persons do not bear any part of the expenses of medical treatment. Sickness funds may, however, collect a tax of 0.10 marks at most, for the delivery of a certificate of illness, except in the case of accidents or contagious diseases (section 187 b).

Drugs and minor appliances in the sense of section 182, No. 1, include material directly used in treating sick persons and aiding in the cure or relief of the illness of the sick person or in the restoration of his capacity for work. On the other hand, hygienic treatment tending towards the re-establishment of health or the prevention of disease, and mere tonics or foodstuffs are not included. Nevertheless, when a special article of diet is prescribed by the doctor for curative purposes, they are considered to be drugs and therapeutic aids (see the general principles laid down by the Federal Committee of Doctors and Sickness Funds dated 15 May 1925 concerning economical prescribing).

Spectacles and bandages must be supplied without consideration of price. Among minor appliances are generally reckoned surgical boots and other supporting apparatus. Other more costly prosthetic apparatus may be granted as additional benefits under section 193, par. 2. The same is the case as

regards other apparatus which insured persons may require under the heading of medical treatment.

Insured persons contribute towards the cost of medicines. In any case 10 per cent of the charge for drugs, appliances and tonics are borne by the insured person. When the managing committee of the fund consider that the expenses falling upon the fund for drugs, appliances and tonics are such as to compromise the financial equilibrium of the fund, they may cause the sick person to contribute up to 20 per cent. of the expenses. Nevertheless, the managing committee is required to reverse its decision on the request of a majority of the representatives of insured persons at the general delegate meeting.

It is the duty of the Federal Committee of Doctors and Sickness Funds to prescribe any exemptions to the rules concerning the contributions of insured persons to the cost of medicines (section 182 a, pars 1 to 3).

The Federal Committee has determined these exemptions in accordance with the following general principles, dated 10 April 1924:

A. Members of funds are exempted from contributing to the expenses of drugs, appliances and tonics:

- (1) in the event of illness resulting from an accident;
- (2) in the event of childbirth necessitating medical assistance;
- (3) in the event of urgent prescriptions given to be made up at night

B. Doctors may make out urgent prescriptions:

- (1) to avert danger to life or health;
- (2) to put a stop to violent pain;
- (3) to take quick measures for the repression of a contagious disorder.

For medical and sickness benefit the fund may substitute treatment and maintenance in a hospital. If the sick person has a home of his own or lives with his family, his consent is necessary. In the case of a minor over 16 years of age, his consent alone is sufficient. Consent is not necessary:

- if the nature of the disease demands treatment or attention which cannot be given in the family of the sick person,
- if the disease is contagious,
- if the sick person has on several occasions infringed the regulations concerning sickness or the prescriptions of the doctor who is attending him;
- if his state of health or conduct demands continual supervision (section 184, pars 1 to 3).

The committee of the fund is free to decide whether or no to send the patient into a hospital, and the insured person cannot claim it in the courts even in a case of urgency. Similarly the supervisory authorities cannot in any given case order the fund to send an insured person into a hospital.

The sending of an insured person to hospital includes the cost of transport to the hospital and, if necessary, the cost of the transport of the invalid back to his home. In the choice of a hospital, the sickness fund is not compelled to confine itself to hospitals in the place of residence of the sick person.

If a sickness fund offers a patient treatment hospital the insured person loses his right to medical benefit and sickness benefit when he refuses to accept it in a case for which the Act does not provide for the necessity of his consent. The same is the case when the person sent to hospital leaves the hospital on his own initiative.

Consent once given by an insured person cannot be revoked at any moment. The insured person is bound by his consent for so long as it is necessary to continue hospital treatment.

If the insured person sent to hospital has a family which he has wholly or largely maintained hitherto out of his wages, a family allowance will be granted to the members of the family equal to half the sickness benefit. This allowance may be paid directly to members of the family (section 186).

With the consent of the insured person, the fund may authorise his attendance by nurses, infirmaries, sisters, or any other nursing staff, in particular when it is desirable but impossible that he should go into a hospital, or when there is a serious reason for leaving the sick person in his own home or in the care of his family (section 185). The fund is free to decide what attention in the home it will grant, and the insured person cannot claim it at law. In the

case of attention given in the home the rules may allow for a reduction of the sickness benefit by one-quarter at most (section 185, par. 2)

Sickness funds responsible for a large district may engage nurses to attend sick persons and to assist the doctors. The Federal Committee of Doctors and Sickness Funds is entitled to lay down the general principles of the work of the nurses (section 185 a)

On 10 April 1924 the Federal Committee laid down the following general principles concerning the work of the nurses.

The principles apply to sickness funds in the country

- (1) only nurses recognised by the State are allowed,
- (2) the work of nurses engaged by the funds as nursing staff and as assistants to the doctor must be confined to attention given to patients and to assistance afforded under medical supervision and direction;
- (3) when a patient or a member of his family has recourse to a nurse, the nurse must recommend the calling in of a doctor. In urgent cases the nurse must herself directly advise the doctor as soon as possible,
- (4) nurses are forbidden (a) to give advice concerning the treatment of persons, (b) to give assistance themselves except in urgent cases, but then only until the doctor arrives, (c) to exert any influence for or against given doctors.

When the doctor considers the attention and assistance of a nurse to be necessary, he must inform the fund

In exceptional cases, sickness funds may substitute payments in cash for benefits in kind.

If, in the working of a sickness fund, the medical attention which it affords is seriously compromised as the result of the fact that the fund cannot conclude suitable contracts with a sufficient number of doctors or because the doctors do not conform to the contract made, the Superior Insurance Office may, with power to revoke its decision, authorise a fund which requests it to grant benefits in cash instead of medical treatment up to an amount equal to two-thirds of the average amount of the statutory sickness benefit (section 370, par. 1).

If an insured person ceases to reside in Germany after the occurrence of the event which gives him a right to benefit, without suspension of sickness benefit, the fund may free itself from its obligations by a lump sum payment in commutation. This sum must be equivalent to the value of the benefits to which the person concerned would be entitled in Germany for the propable duration of his illness. The cost of medical benefit is calculated at three-eighths of the basic wage (section 217, par. 1). In the case of insured persons who voluntarily remain members of the fund, and who are not domiciled in its area, the rules may allow medical treatment to be replaced by at least one-half of the sickness allowance (section 193, par. 3.)

Additional Benefits

Additional benefits in kind may be introduced by the funds to the extent provided for in the Code. Once introduced, such additional benefits are the right of all insured persons, and the grant of them cannot in individual cases be left to the arbitrary decision of the management committee.

The additional benefits provided for by the Code are as follows.

- (1) the duration of sickness relief may be extended to one year (section 187, No. 1);
- (2) the rules may allow assistance to convalescents; in particular, their admission to convalescent homes for a year at most as from the date of the expiry of the period of sickness benefit (section 187, No. 2);
- (3) the rules may, at the end of the period of curative treatment, afford the patient the necessary apparatus to prevent deformity or lameness of any kind with the object of restoring or maintaining the capacity to work (section 187, No. 3).

The rules may, with the consent of the Superior Insurance Office, fix a maximum amount for minor appliances. They may also add to the treatment.

forms of relief other than minor appliances, e.g. they may supply the sick person with invalid diet or grant him a special supplementary allowance to pay for it

In addition, the rules may

bring the family allowance (in the case of the sick person going into a hospital) up to the legal amount of sickness benefit, grant insured persons who do not benefit by family allowances, in addition to sending them into a hospital, a sickness allowance equivalent to half the statutory sickness benefit (section 194)

STATISTICS

The following table gives the total cost of benefits in kind, the average cost per insured person, and the relation between the cost of benefits in kind and the total cost of all benefits

TOTAL AND AVERAGE COST PER INSURED PERSON OF BENEFITS IN KIND IN FUNDS WORKING UNDER THE FEDERAL INSURANCE CODE

(a) Total cost in thousands of marks. (b) Average cost per insured person in marks.
(c) Percentage of the total cost of benefits

Nature of benefits	1914			1924		
	(a)	(b)	(c)	(a)	(b)	(c)
Medical treatment	104,041	6.67	23.4	205,729	11.90	26.1
Dental treatment	7,830	0.50	1.8	21,219	1.22	2.7
Nurses' salaries	4,552	0.29	1.0	15,866	0.92	2.0
Pharmaceutical assistance	58,505	3.74	13.1	92,336	5.34	11.7
Hospital treatment	62,858	4.03	14.2	109,349	6.33	13.9
Home nursing.	174	0.01	—	98	0.01	—
Assistance for convalescents	292	0.02	0.1	2,379	0.14	0.3
Maternity treatment	108	0.01	—	313	0.02	—
Other forms of assistance	—	—	—	11,095	0.64	1.4
Benefits in kind	238,360	15.27	53.6	458,294	26.51	58.1
Benefits in cash	206,413	13.22	46.4	331,523	19.18	41.9
Total	444,773	28.49	100.0	789,817	45.69	100.0

The following table shows in the case of miners' sickness insurance the total cost and the average cost per insured person for the various types of benefits in kind

TOTAL AND AVERAGE COST PER INSURED PERSON FOR BENEFITS IN KIND IN MINERS' SICKNESS INSURANCE

(a) Total cost in marks. (b) Average cost per insured person in marks.

Nature of benefits	1924	
	(a)	(b)
Medical treatment	9,461,149	10.8
Dental treatment	393,657	0.4
Nurses' salaries	294,345	0.3
Pharmaceutical assistance	4,253,665	4.8
Hospital treatment	12,408,900	14.2
Home nursing	1,125	0.0
Assistance for convalescents	281,675	0.3
Maternity treatment	6,846	0.0
Other forms of assistance	871,333	1.0
Welfare in general	187,741	0.2
Total benefits in kind	28,150,436	32.0

GREAT BRITAIN

LEGISLATION

Act of 7 August 1924

The legal benefits in kind comprise medical and pharmaceutical assistance. Up to the month of May 1921 sanatorium treatment for tuberculous patients was also a legal benefit. Since that period such treatment has been entrusted to the local authorities as it is considered indispensable that the whole population should benefit by it.

Conditions under which Benefits are Granted

Every insured person (with the exception of members of the Army and Navy, seamen on foreign-going ships, and persons voluntarily insured who have an income in excess of £250 in year) is entitled to medical benefit from the moment of his becoming subject to insurance. He has only to show that he holds an employment involving the obligation to insure and to produce evidence of the fact. There is no qualifying period or waiting period for the purposes of medical benefit and the title to medical benefit is not affected by arrears of contributions.

There is also no limit to the duration of the right to medical benefit. The insured is entitled to it as long as he requires it. An insured person who ceases to be employed in an occupation involving the obligation to insure retains all his rights to benefits for one year (exclusive of periods of duly notified incapacity). After that time he continues to be entitled to medical benefit until 30 June or 31 December next after the expiration of a period of six months from the date on which he ceases to be an insured person (section 12, subsection 4, of the National Health Insurance Act, 1924). Thus, the right to medical benefit continues for at least 18 months and not more than two years after the cessation of insurance. After attaining the age of 70 (65 as from 2 January 1928) an insured person continues to be entitled to medical benefit for the rest of his life provided at least 27 weekly contributions had been paid before he attained that age.

Legal Benefits

Medical treatment for the purposes of the Act is defined as follows: the treatment which a practitioner is required to give to his patients comprises all proper and necessary medical services other than those involving the application of special skill and experience of a degree or kind which general practitioners as a class cannot reasonably be expected to possess. Such services include either the administration of anæsthetics or the rendering of other assistance at any operation which is performed and is of a kind usually performed by a medical practitioner, whether the operation is itself within the scope of the practitioner's obligation under this clause or not, wherever such administration or assistance does not involve the application of special skill or experience of a degree or kind which general practitioners as a class cannot reasonably be expected to possess. In the case of emergency the practitioner is required to render whatever services are, having regard to the circumstances, in the best interest of the patient (Medical Benefit Consolidated Regulations, 1924, First Schedule, Part I (8)). Although the Act itself does not limit the medical treatment to be given by a general practitioner, it has been found necessary to introduce such a limitation inasmuch as any general practitioner may undertake the treatment of patients under the Insurance Act. The insured may only have recourse to one practitioner at a time (*Royal Commission, Evidence*, Question 999).

It should be noted that the medical benefit granted under sickness insurance does not include treatment by specialists or laboratory service. Similarly, treatment in hospital is not a benefit granted under the National Insurance Act, so that if, for example, an insured person has to undergo an operation he must, if he is without means, have recourse to the institutions maintained by the poor law authorities or obtain admission to a hospital in which he will be treated gratuitously or subject to payment at rates fixed in accordance with the patient's means.

Pharmaceutical assistance comprises the provision of proper and sufficient medicines. The patient is entitled to receive any drug, however expensive, which is necessary for his proper treatment. On the other hand, articles in the nature of foods or stimulants are not furnished gratuitously to patients (section 10, subsection 2, of the Act, and *Royal Commission, Evidence, Appendix, Part I, page 87*).

Medical appliances which may be furnished are determined by regulations, and include bandages, gauzes, ice bags, syringes, etc. (Medical Benefit Consolidated Regulations, 1924, Second Schedule), but not including surgical appliances such as surgical boots and artificial limbs (*Royal Commission, Evidence, Questions 1361 and 1362.*)

The Act allows approved societies to substitute additional benefits for benefits in kind with the approval of the Minister (section 18). It may, however, be noted that only two societies have availed themselves of this power.

Additional Benefits

Additional benefits may only be granted by approved societies whose quinquennial valuation shows a surplus. Such societies may freely choose the kind of additional benefits which they will grant. These consist for the most part in payments for covering certain forms of special treatment.

The principal additional benefits, apart from additional benefits in cash to which reference has been previously made (see page 229), are the following:

- Payment of the cost of dental treatment,
- Maintenance in hospitals and convalescent homes;
- Payment of the expenses of medical and surgical appliances not included in statutory benefits,
- Payment of the cost of optical treatment and spectacles;
- Payment for the provision of nurses

(Third Schedule to the Act and *Royal Commission, Evidence, Appendix, Part I, page 52.*)

A certain number of other benefits contemplated by the Act are very rarely chosen by approved societies.

Dental treatment includes extraction filling, stopping and the provision of artificial teeth. The proportion of dental costs borne by the societies at first varied, some of them paying the whole and others only half or even less of such costs (*Royal Commission, Evidence, Appendix, Part I, page 52*). There is now, however, a scale of fees for dentists which has been accepted by a large number of approved societies which ordinarily bear the whole cost of treatment and half the cost of dentures; and insured persons have a right to go to any dentist among those who have accepted such scale (*Royal Commission, Evidence, Question 23915*).

Where treatment and maintenance in a hospital or convalescent home is given as an additional benefit, the approved society may pay the hospital or convalescent home an annual sum, in anticipation of a member requiring treatment therein. There is also another method of payment under which the approved society undertakes to pay 25s. or 30s. per week for each member treated (*Royal Commission, Evidence, Appendix, Part I, page 52*).

The medical and surgical appliances furnished by way of additional benefits generally comprise surgical boots, artificial limbs, etc. The society in some cases pays the whole and in others half of the price of such appliances, the average cost per case in some societies being between 30s. and 40s. (*Royal Commission, Evidence, Appendix, Part I, page 52*). The cost of optical treatment and spectacles amounts to about 15s. for each beneficiary (*Royal Commission, Evidence, Appendix, Part I, page 53*). An ophthalmic surgeon may be consulted. The provision of nurses is generally carried out by an arrangement with a nursing organisation. Payment is at the rate of 1s. 4d. per visit, of which the society generally pay 1s. and the insured 4d. (*Royal Commission, Evidence, Appendix, Part I, page 53*).

STATISTICS

The following table shows the total expense for the principal benefits in kind

TOTAL COST OF PRINCIPAL BENEFITS IN KIND IN THOUSANDS OF £

Year	Medical treatment	Medical expenses	Pharmaceutical services	Other benefits in kind	Total cost of benefits in kind
1914	5,620	—	—	18	6,437
1915	4,570	—	—	27	5,342
1916	5,010	—	—	37	5,702
1917	4,728	—	—	65	5,518
1918	5,561	—	—	116	6,420
1919	6,507	—	—	290	7,740
1920	10,017	—	—	61	11,101
1921	10,710	—	1,615	46 ¹	11,315
1922	9,614	—	1,615	247	10,006
1923	9,198	7,308	1,643	617	9,871
1924	9,194	7,095	1,930	709	9,909
1925	9,453	7,124	2,010	915	10,404

¹ Since 4 July 1921 additional benefits in kind have been paid. Up to that date cash benefits were given in place of benefits in kind.

The average cost of benefits in kind and the proportion which that cost bears to the total proportion which that cost bears to the total cost of insurance appears from the following table.

AVERAGE COST OF BENEFITS IN KIND PER INSURED PERSON

Year	Cost per insured person	Percentage of total cost of insurance
	In £ sterling	Per cent.
1914	0 37	37
1915	0 38	34
1916	0 38	36
1917	0 36	36
1918	0 40	37
1919	0 56	40
1920	0 73	42
1921	0 75	38
1922	0 66	34
1923	0 65	34
1924	0 65	29
1925	0 66	32

In the first period of additional benefits, based on the valuation of 31 December 1918 and extending from July 1921 to July 1926, there were

7,349 approved societies with 14,048,485 members which granted additional benefits, of these, 1,140 with 4,728,069 members granted additional benefits in cash and in kind and 168 with 4,658,196 members benefits in kind only.

The following table shows the number and membership of the approved societies granting additional benefits in kind.

ADDITIONAL BENEFITS IN KIND GRANTED IN THE YEARS 1921-1924

Nature of additional benefits	Number of approved societies	Number of members (in thousands)	Annual expenditure (in thousands of £)		
			1921-1922	1922-1923	1923-1924
Dental treatment	564	7,474	72	270	351.5
Allowances to convalescents	21	56	0 17	0.12	0 03
Leasing convalescent homes	3	52	6.4	5.9	4.3
Payments to members in want or distress (including remission of contributions in arrear	39	2,434	3.1	2.8	2.9
Return of contributions	8	26	12.3	8.6	5 9
Hospital treatment	1,040	8,406	147	243.6	232.8
Surgical appliances	343	6,265	3.4	5.3	7.7
Cost of optical treatment	443	6,191	7.7	14.0	32.7
Cost of nurses	293	6,766	4.7	7.6	7.1

In the second period of additional benefits there are two groups of societies, one whose valuation was made in 1922 and the other in 1923

Particulars are given as regards both groups comprising 7,864 societies and branches and 15,000,000 members

The following table shows the nature and amount of additional benefits in kind granted by both groups of societies:

Nature of additional benefits in kind	Number of societies	Number of persons (in thousands)	Amount of expenditure per annum provided for (in thousands of £)
Medical treatment for members of family	3	1 3	0 2
Dental treatment	6,961	14,061	2,888 7
Allowances to partially disabled persons	1	1	0.05
Allowances to convalescents	23	84 5	4 6
Treatment in convalescent homes	2,347	10,761	230.2
Hospital treatment	2,076	9,461	319 4
Surgical appliances	3,638	12,178	140.5
Cost of optical treatment	6,172	13,140	465.9
Cost of nurses	470	3,016 5	24.3

If the results of the first and second periods of additional benefits are compared, it will be seen that as regards the application of the available surpluses 71 per cent. of such surpluses was applied to cash benefits and 29 per cent. to benefits in kind in the first period, while in the second period the corresponding figures are 52 and 48 respectively, which shows an appreciable increase in the expenditure on benefits in kind.

HUNGARY

LEGISLATION

Act No. XIX of 6 April 1907

The benefits in kind provided for by the law are—

- (a) medical treatment;
- (b) medicines, baths, mineral waters, and certain surgical appliances;
- (c) treatment in hospital with full maintenance subject to certain conditions.

Conditions under which Benefits are Granted

Every insured person is entitled to benefits in kind from the date of his entering an occupation involving the obligation to insure. No qualifying period or waiting period is imposed on the insured in order that he may be entitled to benefits in kind. By way of exception, certain appliances, such as spectacles, trusses, crutches and surgical appliances are only allowed to insured persons who have been members of the national workers' insurance fund for one or two years before claiming such benefits (Order 5400 of 1919).

The period during which the insured person is entitled to benefits in kind, which was originally 20 weeks, and later 26 weeks, was raised by the Order 5400 of 1919 to one year.

Legal Benefits

The insured must go to the doctor or doctors appointed by his fund, except in urgent cases, the fund is not bound to repay expenses incurred for the services of another practitioner.

Dental treatment is a statutory benefit so far as it is necessary for the preservation of the teeth. Artificial teeth are not furnished at the expense of the insurance fund except for the purpose of maintaining the earning capacity of the insured, and then only to members who have belonged to the fund for at least one year during the two years immediately preceding. Artificial teeth are never supplied merely for the sake of preserving the appearance (Order 5400 of 1919).

Treatment at a bathing establishment does not in principle include the maintenance of the patient. Where, however, the condition of the insured requires such treatment elsewhere than in his place of residence, the insured may claim maintenance in addition to treatment (Order 5400 of 1919). Pharmaceutical assistance includes medicine and mineral waters, and medical and surgical appliances, such as spectacles, crutches, trusses, etc.

Hospital treatment is also a statutory benefit, but only where the condition of the insured requires it. In other cases the fund may order hospital treatment, either at the request of the insured or with his consent. Hospital treatment may be ordered without the consent of the patient where the nature of the disease requires it or the insured has not observed the orders of the doctor, and has thus delayed his recovery, or finally, where the necessary treatment cannot be given to the insured in his own home (Order 6100 of 1923).

Hospital treatment may be refused to an insured person for one year if he has declined to accept the hospital treatment ordered by the fund or has left the hospital prematurely and without sufficient reason (Order 8022 of 1924).

A patient undergoing a hospital treatment cannot during such treatment claim any other benefit. The members of his family residing with him and not themselves insured are, however, entitled to half the sickness benefit which would have been payable to the insured if he had not been undergoing hospital treatment.

Additional Benefits

Since the extension of the period of legal benefits to 52 weeks, additional benefits have consisted of special treatment. Thus insured persons suffering from tuberculosis receive, in addition to the statutory benefits, the amount of milk necessary for their sustenance (Order 4790 of 1917). Further, surgical

appliances of an expensive character, which would ordinarily only be allowed to insured persons who had been members of the fund for at least one year during the two preceding years, may be allowed as additional benefits without any special qualifying period (Order 8888 of 1922).

Finally, artificial teeth, which are ordinarily only allowed to members who have belonged to the fund for at least one year during the two preceding years, may be granted without any such qualifying period of membership by way of additional benefits (Order 8888 of 1922).

In principle, the insured is entitled to the benefits in kind in exceptional cases where the fund is unable to furnish the insured with medical treatment or medicines the amount of sickness benefit must be doubled (section 55, par. 4).

STATISTICS

The following table indicates the average cost per head of the benefits in kind and the percentage of the total insurance receipts attributed to such benefits.

AVERAGE COST PER INSURED OF BENEFITS IN KIND AND PROPORTION OF THE SAME TO THE TOTAL BENEFITS

Year	Average cost per head	Percentage of total cost of benefits
	Crowns	Per cent.
1913	12.32	53.1
1914	12.37	56.7
1919	59.60	40.8
1920	110	51.6
1921	214	49.7
1922	663	61.9
1923	15,507	68
1924	158,250	49.1

The amounts in the above table represent the cost of medical treatment, hydrotherapy, hospital treatment and medicines. The following table shows the distribution of the total cost of benefits in kind, firstly per head and secondly in proportion to the total insurance receipts.

DISTRIBUTION OF VARIOUS BENEFITS

(a) Average cost per member in crowns. (b) Percentage of the total cost of benefits.

Year	Medical treatment		Treatment in bathing establishments and sanatoria		Hospital treatment		Drugs	
	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
1913	5.10	22.0	1.74	4.5	2.28	9.4	3.53	15.2
1914	5.62	25.8	0.86	3.9	2.14	9.8	3.38	15.5
1919	17.73	42.0	2.30	1.8	25.31	17.2	13.86	6.1
1920	32.75	15.0	2.95	1.3	34	15.8	42	19.3
1921	66	15.2	17	3.9	51	11.8	80	18.4
1922	184	17.0	87	8.1	181	16.8	210	19.5
1923	3,298	14.4	1,394	6.1	5,370	23.4	5,443	24.6
1924	55,069	16.9	16,250	4.9	39,084	11.9	47,815	11.6

IRISH FREE STATE

LEGISLATION

Act of 16 December 1911

Medical treatment is not a statutory benefit, but insured persons suffering from tuberculosis can claim sanatorium treatment.

Legal Benefits

The treatment of tubercular patients in a sanatorium or similar institution or treatment at a dispensary is granted on the proposal of the Insurance Committee, whilst benefit may, on the advice of the Committee, be extended to members of the family of the insured.

Additional Benefits

The Act authorises the introduction of the following benefits by means of regulations

- (a) Medical treatment
- (b) Medical treatment of persons dependent on the insured.
- (c) The repayment of the whole or part of the expenses of additional treatment
- (d) Treatment for convalescents
- (e) Payment of the whole or part of the expenses of hospital treatment and repayment of expenses of conveyance to hospital.
- (f) The payment of the whole or part of the cost of medicines.
- (g) The payment of the whole or part of the expense of optical treatment.
- (h) The repayment of the cost of nurses.
- (i) The payment of the whole or part of the expense of hospital treatment for members of the family of the insured

The types of additional benefit actually granted are dental treatment, hospital treatment, optical treatment, and medicines.

STATISTICS

The total expenditure for benefits in kind amounted in 1925 to £30,433, £24,960 of which was sanatorium treatment of tuberculosis, £3,549 for dental treatment, £1,675 for hospital treatment, and £248 for optical treatment

Benefits in kind in 1925 only absorbed 4.25 per cent of the total cost of insurance

JAPAN

Act of 22 April 1922

Insured persons are entitled to medical attendance and, if necessary, to hospital treatment.

Conditions under which Benefits are Granted

Benefits in kind are granted without regard to the period of membership of an insurance society: such benefits may be granted for 180 days in the same year (section 47 of the Act)

Legal Benefits

Medical attendance comprises medical diagnosis, the supply of medicines, and, where necessary, operations and special treatment. The cost of the last-named benefits, however, must not exceed 20 yen, except in urgent cases, without the express authorisation of the insurance society.

The insurance society may, in addition to the above benefits, allow the assistance of nurses and free transport (section 74 of the Order). The insurance society may allow treatment in hospital, but in that case the sickness benefit is liable to reduction (section 46)

Where an insurance society finds it difficult to organise a medical service, or where the insured person is, with the consent of the insurance society,

treated by a practitioner not attached to the society, or where such treatment is indispensable in an urgent case, a cash benefit may be allowed in lieu of medical benefit to an amount determined with regard to the expenses which the insurance society would have incurred if treatment had been given by a practitioner engaged by such society (section 44 of the Act and sections 77 and 78 of the Order).

LATVIA

The legal provisions resemble those in force in Esthonia, see page 301.

LITHUANIA

Act of 23 June 1912

The benefits in kind provided for by law are:

- (a) medical first aid in case of sudden illness.
- (b) medical attendance in dispensaries;
- (c) treatment at home;
- (d) treatment in hospital,
- (e) drugs.

Legal Benefits

The medical practitioners attached to the insurance funds must arrange fixed hours for consultations either in surgeries or in any other place which may be determined by the committee of the fund (section 33). Dental treatment only comprises ordinary treatment, including filling and stopping. The insured must himself bear the cost of artificial teeth and of unusually expert stoppings (section 34).

Medical attendance is free. If, however, the insured consults a doctor whose name does not appear on the list prepared by the committee of the fund, he must bear the additional expense occasioned by such consultation (section 30).

Hospital treatment is granted at the expense of the insurance fund. The insured may choose the hospital in which he desires to be treated. If, however, he selects a hospital the charges of which are higher than those fixed by the committee of the fund, he must bear the additional cost (sections 31 and 32). The substitution of a cash benefit for benefits in kind is only allowed where the fund is unable to conclude an agreement with a sufficient number of practitioners or is for any other reason unable to furnish benefits in kind. The substitution is subject to the consent of the Superior Office of Social Insurance (section 41).

LUXEMBURG

LEGISLATION

Social Insurance Code of 17 December 1925

Medical benefit includes medical treatment, drugs and certain medical appliances (section 8, par 1).

Conditions under which Benefits are Granted

Compulsorily insured persons are entitled to the benefits in kind from the day of their becoming the subject of insurance. As regards voluntarily insured persons the regulations of insurance institutions may provide for a qualifying period of not more than six weeks (section 16, par 3 a).

Medical attendance is allowed from the commencement of the illness: it ceases at the expiration of the twenty-sixth week of the illness or, if pecuniary benefit is only granted from a later date, at the expiration of the twenty-sixth week from that date. If during the same illness sickness benefit is interrupted by a period during which only medical attendance and medicines are furnished, such period up to 13 weeks is not taken into account in calculating the period of illness and sickness benefit. Where sickness benefit continues after the expiration of the twenty-sixth week from the beginning of the illness, the right to medical attendance only ceases with such sickness benefit.

Legal Benefits

Contribution by the insured to the costs of medical attendance may be required by the rules of a fund. The managing committee with the consent of the central committee may decide that insured persons enjoying benefit of medical treatment and drugs shall bear a proportion of the expenses of such benefits or of certain elements only, but so that the proportion borne by the insured shall not exceed a quarter (section 306).

In lieu of medical attendance, the fund may grant treatment and maintenance in hospital; if the insured has his own household or lives with his family, his consent is necessary. The consent of a minor over 16 years of age is sufficient without any other consent.

The consent of the insured is not necessary.

- (1) if the nature of the disease requires treatment or attendance which cannot be given in the home of the insured,
- (2) if the disease is contagious,
- (3) if the insured has on several occasions disobeyed the orders of the fund or the doctor in attendance;
- (4) if his condition or behaviour require continuous supervision

If the insured person undergoing hospital treatment has a family which he has hitherto entirely or to a large extent maintained, the members of such family are entitled to a family allowance equal to half of the sickness benefit. Such benefit may be paid directly to the members of the family (section 9, pars. 1, 2 and 4).

The fund may also with the consent of the insured grant the assistance of a nurse in cases where treatment in hospital has been demanded but cannot be given or where there are good reasons for leaving the patient with his family or in his home. In such cases the regulations of the fund may provide that the sickness benefit may be reduced by not more than a quarter (section 9, par. 3).

The substitution of a cash benefit for benefits in kind is allowed in the following cases.

- (1) The rules may provide that, in the case of insured persons who have continued insurance voluntarily and who are not resident within the district of the fund, not less than half the sickness benefit may be substituted for medical treatment (section 10, last par.).
- (2) If the medical treatment is rendered particularly difficult by the fact that the fund has not been able to obtain on suitable terms the assistance of a sufficient number of practitioners, the managing committee may in lieu of medical treatment grant a cash benefit not exceeding three-eighths of the average amount of the sickness benefit paid by the fund (section 305, par. 1).

Additional Benefits

An optional qualifying period of not more than six months may be introduced by rule in the case of compulsorily insured persons for the acquisition of the right to additional benefits. Such provision is not, however, applicable to insured persons who during the twelve preceding months have already been entitled for at least six months to additional benefits from another fund. The qualifying period is not suspended by interruption in membership not exceeding 26 weeks (section 16, pars. 3 and 4).

The rules of the fund may.

- (i) extend up to one year the period of sickness benefit,
- (ii) grant assistance to convalescents, particularly by sending them to convalescent homes for not more than one year from the expiration of sickness benefit;
- (iii) grant at the expiration of medical treatment the necessary assistance and appliances for preventing deformity or mutilation and restoring or maintaining capacity for work,
- (iv) increase the allowance to the family of an insured person undergoing hospital treatment up to the amount of the sickness benefit, or grant

- to insured persons undergoing hospital treatment in respect of whom no family allowance is payable, in addition to the treatment and maintenance in hospital, a cash benefit equal to half the sickness benefit.
- (v) establish a maximum value for medical appliances of minor importance and provide that the fund may grant an allowance up to the amount of such maximum for the acquisition of more important medical appliances (section 10, pars 1, 2, 3, 5, and 7.).

It should be noted that the rules of funds may authorise the organisation of a service of preventive medicine (section 10, par 8).

STATISTICS

The following table shows the total expenditure on the three principal kinds of medical benefit in thousands of francs:

Year	Cost of medical treatment	Cost of drugs, etc.	Cost of hospital treatment	Total
1913	526	428	186	1,140
1919	781	545	194	1,520
1920	1,083	693	265	2,041
1921	1,216	1,009	409	2,634
1922	1,490	1,150	473	3,113
1923	1,707	1,203	573	3,483

(Reports published by the Department of Agriculture and Social Welfare.)

The following table shows the average expenditure per insured person and the expenditure for various benefits in kind in relation to the total cost of benefits.

AVERAGE EXPENDITURE PER INSURED PERSON FOR BENEFITS IN KIND AND PROPORTION OF COST OF BENEFITS IN KIND TO TOTAL COST OF BENEFITS

(a) Average expenditure per insured person in francs. (b) Percentage of total cost of benefits

Year	Cost of medical treatment		Cost of drugs, etc		Cost of hospital treatment		Total benefits	
	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
1913	12 10	24 27	9.86	19.73	4.29	8 59	26.25	52.59
1919	20 83	22 83	14.56	15 93	5 17	5.68	40.56	44.44
1920	28.28	30 53	18.13	19 52	7.43	7.48	53.84	57.53
1921	31 85	28 84	26.47	21 44	10.46	8.68	68.78	58.96
1922	34 40	27 89	26.55	21.51	10.98	8 85	71.94	58.25
1923	36.28	30.15	25.60	21.25	12 16	10.13	74.04	61.53

(Reports published by the Department of Agriculture and Social Welfare.)

NORWAY

LEGISLATION

Act of 6 August 1915

The benefits provided for by law are:

- (1) medical treatment, including dental treatment
- (2) supply of certain appliances, such as spectacles trusses and bandaging material.

Conditions under which Benefits are Granted

An insured person is entitled to benefits in kind from the moment of becoming subject to insurance. The Act of 17 July 1925 abolished all limitation of the duration of medical attendance, which is granted to insured persons as long as they remain members of the fund.

If an insured without any reason recognised as valid by law refuses to undergo hospital treatment, he ceases to be entitled to benefit. His dependants, however, may receive a family allowance (section 18, subsection 2, par 1).

Any insured person who has deliberately provoked his illness or become intoxicated loses his right to gratuitous hospital treatment. Hospital treatment may, nevertheless, be allowed him if this is more advantageous to the insurance fund or will be the means of avoiding permanent physical injury, but the fund may obtain repayment from the insured of all expenses so incurred (section 26, subsection 2).

Legal Benefits

Under the Act of 6 August 1915, insured persons were entitled to free medical treatment, but a cash benefit might be substituted for such treatment. The new Act of 17 July 1925 only provides for a repayment in accordance with an established scale of the cost of medical treatment, including dental treatment. The scale of 3 December 1925 fixes the amount repayable by the funds for various benefits in kind. Extraction of teeth is assimilated to medical treatment except where it is carried out for the purpose of supplying artificial teeth (section 16, subsection 1, A, (a)).

Drugs are not an insurance benefit. Where, however, sickness is due to injury occasioned by an industrial accident, giving rise to a right to compensation under the Accident Insurance Act, the fund must also furnish the medicine ordered by the doctor (section 16, subsection 1, A, (b)).

On the other hand, the funds must furnish the insured persons in the first instance with certain appliances such as spectacles, trusses, etc., and, where surgical treatment is necessary, with bandages and other appliances necessary for the purpose and prescribed by the practitioner (section 16, subsection 1, A, (a)).

Free treatment in a hospital or sanatorium may be substituted for medical benefit. In the case of an industrial accident, the Royal Insurance Office may require the hospital treatment of the victim (section 16, par 1).

STATISTICS

The following tables show the amount and nature of benefits in kind

TOTAL EXPENDITURE ON BENEFITS IN KIND BY ALL INSURANCE FUNDS
(IN THOUSANDS OF CROWNS)

Year	Hospital treatment	Medical fees	Dental fees	Travelling expenses of practitioners and transport of patients	Medical appliances, baths, etc.	Total
1917	1,326	3,810	305	426	294	6,161
1918	1,931	6,173	400	749	388	9,641
1919	2,602	8,058	465	1,073	553	12,751
1920	3,269	9,034	551	1,263	744	14,861
1921	3,973	9,942	742	1,353	978	16,988
1922	4,473	11,194	825	1,417	1,021	18,930
1923	4,693	8,858	644	1,289	1,064	16,548
1924	5,316	9,577	777	1,388	1,254	18,272

(Official Statistics of the Kingdom of Norway.)

AVERAGE EXPENDITURE PER MEMBER ON VARIOUS BENEFITS IN KIND AND ITS
PROPORTION TO TOTAL EXPENDITURE

(a) Average expenditure per member in crowns (b) Percentage of total expenditure.

Year	Hospital treatment		Medical fees		Dental fees		Travelling expenses of practitioners and transport of patients		Medical appliances, baths, etc.		Total	
	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
1917	2.8	10	8	28.7	0.6	2.3	0.9	3.2	0.6	2.2	12.9	46.4
1918	3.7	8.2	11.9	26.2	0.7	1.7	1.4	3.2	0.8	1.6	18.5	40.9
1919	4.8	8.2	14.8	25.6	0.8	1.5	2.0	3.4	1.0	1.8	23.4	40.5
1920	5.9	9.7	16.2	26.9	1	1.6	2.3	3.8	1.3	2.2	26.7	44.2
1921	7.3	11.2	18.1	28	1.35	2.1	2.5	3.8	1.8	2.8	31.05	47.9
1922	7.8	11.1	19.6	27.8	1.45	2.1	2.5	3.5	1.8	2.5	33.15	47.0
1923	8.1	13.3	15.3	25.2	1.11	1.8	2.2	3.7	1.8	3	28.51	47.0
1924	9.1	14.7	16.4	26.6	1.26	2.1	2.4	3.8	2.1	3.5	31.26	50.7

(Official Statistics of the Kingdom of Norway.)

POLAND

LEGISLATION

Act of 19 May 1920

The law grants insured persons medical and pharmaceutical assistance and, if necessary, treatment in a hospital.

Conditions under which Benefits are Granted

Compulsorily insured persons, with the exception of home workers and temporary workers acquire the right to benefits as from the day on which they begin work in any occupation which implies the obligation to insure. Home workers, temporary workers and voluntarily insured persons have to complete a qualifying period, the minimum duration of which is four weeks and the maximum six weeks (section 35).

Legal Benefits

Medical assistance is granted as from the first day of the illness for 26 weeks at least. Funds, however, which have existed for more than three years are required to extend the duration of assistance to 39 weeks.

Pharmaceutical assistance includes the supply of drugs, bandages, spectacles and other therapeutic aids the object of which is to restore the patient to health and earning capacity, together with any apparatus for preventing deformities, mutilations and for preserving the patient's capacity for work.

Assistance must be given in kind; as an exceptional measure, a fund which is unable to provide its members with medical assistance may be authorised by the supervisory authorities to grant pecuniary relief instead of medical benefit up to a sum equivalent to two-thirds of the sickness benefit (section 23, pars. 1 and 3).

Medical benefit and sickness benefit may with the consent of the person concerned be replaced by treatment and maintenance in a hospital. An insured person may be treated in a hospital without his consent in the following cases:

- if the nature of the disease demands treatment and attention which cannot be given at home;
- if the disease is contagious;
- if the state or conduct of the patient demands continual supervision;

if on several occasions the patient has refused to comply with the doctor's orders

The sickness fund may also order treatment in the patient's home by the nursing staff

The fund is required to pay to insured persons undergoing treatment in a hospital who have dependent on them one or more members of their family an allowance equivalent to half the sickness benefit. Patients who are not entitled to such allowance receive in addition to treatment and maintenance in the hospital a bonus equivalent to one-tenth of their basic wage (sections 28 and 29)

Additional Benefits

The rules of the fund may extend the duration of medical assistance to a maximum period of 52 weeks

Further, if the resources of the fund are sufficient to cover compulsory benefits and if the reserve fund has reached a sum equivalent to average annual expenditure the fund may introduce the following additional benefits:

the grant of appliances of a particularly costly nature not generally granted as legal benefits,

an increase in the family allowance during the period of treatment in hospital; special assistance for convalescents (section 34).

STATISTICS ¹

The total expenditure on benefits in kind in 1924 was as follows (for 153 funds covered by the statistics):

	Million zloty
Medical treatment	18.16
Hospital treatment	9.32
Cost of drugs	11.02

Benefits in kind accounted for about 46 per cent. of the contributions received during 1924 divided as follows:

	Per cent.
Medical treatment	21.40
Hospital treatment	11.40
Cost of drugs	13.09

The average expenditure per insured person in 1924 was as follows:

	Zloty
Medical treatment	12.55
Hospital treatment	6.53
Cost of drugs	7.68

PORTUGAL

Decree of 10 May 1919

Members of mutual benefit societies are entitled to medical relief and to the free supply of drugs.

Conditions under which Benefits are Granted

The right to benefits in kind is acquired three months after payment of the first contribution on condition that the insured person contributes regularly (section 28).

Statutory Benefits

Medical treatment is granted either at the dispensary or at the home of the patient when the latter cannot leave his home without endangering his health (section 28, No. 1). The mutual benefit society engages a dental surgeon who is at the disposal of the members (section 28, par. 3).

¹ Official Statistics of Sickness Funds in 1924, Ministry of Labour and Social Assistance.

Medical attendance is free. Nevertheless a member who is attended by a doctor other than one of the doctors of the mutual benefit society must bear the cost of any difference between that doctor's fees and the tariff established by the mutual benefit society (section 28, par. 2).

Pharmaceutical assistance includes the drugs prescribed by the mutual benefit society's doctor (section 28, No. 2).

Additional Benefits

Members of mutual benefit societies who have contributed for at least six months may, on the proposal of the mutual benefit society's doctor, receive pecuniary subsidies for the purpose of allowing them to spend 30 days at most in the country as convalescents; they may also be granted up to 20 curative baths in any year (section 30, No. 2).

Whenever their financial resources permit, the societies must on their own initiative or with the assistance of any other local welfare institution set up crèches and nursing homes. They are also required to organise assistance for young children at school and for apprentices and young persons employed in factories. Furthermore, they may, with the authorisation of the social insurance institution, set up workers' clinics, organise hygiene courses and assist in any work for the improvement of social hygiene (section 39).

ROUMANIA

LEGISLATION

Act of 25 January 1912

Insured persons are entitled to medical treatment and drugs and, if necessary, to treatment in hospital.

Conditions under which Benefits are Granted

There is no qualifying or waiting period for medical benefit. Thus, insured persons are from the outset and whatever the duration of their membership entitled to benefits in kind. This rule obtains not only in the former Kingdom, but also in Ardeal and Bukovina.

In the former Kingdom and Bessarabia medical benefit is given for 16 weeks at most. The right to such benefits expires four weeks after the payment of contributions is interrupted, whereas the insured person loses his right to benefit in cash as soon as he interrupts his payment of contributions (section 118 of the Act of 1912).

In Ardeal and Bukovina medical benefit is granted for a maximum period of 26 weeks.

Legal Benefits

Medical assistance includes consultations at dispensaries and, if necessary, treatment at home or in hospital.

Pharmaceutical assistance includes the free supply of drugs, bandages, etc., and other objects of the same kind, and in Ardeal it also includes baths and mineral waters.

In the former Kingdom and Bukovina treatment in hospital may be prescribed without the consent of the patient:

- when the nature of the disease demands care which the family of the patient cannot give;
- if the disease is contagious;
- if the patient has on several occasions ignored the orders of the doctor attending him;
- if the state or conduct of the patient demands continual supervision (section 119 of the Act of 1912).

When a patient under treatment in a hospital has a family dependent on him the sick pay is equivalent to 25 per cent., or if he has not a family to 10 per cent., of the average wage in the wage class to which he belongs (section 117, last par.).

STATISTICS¹

The following tables give for the former Kingdom, Ardeal and Bukovina separately information concerning the total expenditure on insurance and on the proportion of such expenditure absorbed by the various benefits in kind:

PROPORTION OF EXPENDITURE ON VARIOUS TYPES OF BENEFITS IN KIND AND THE TOTAL EXPENDITURE

(1) *Former Kingdom*

Year	Total expenditure including administrative costs (in millions of lei)	Cost of drugs as percentage of the total expenditure	Medical charges as percentage of the total expenditure	Charges for hospital treatment as a percentage of the total expenditure
1912	1 80	19 97	30 90	3 32
1913	2 84	12 02	18.93	6.03
1914	1 96	15 27	24.10	4.97
1915	1.67	11 89	26 94	5.41
1916	1 04	8.82	26 80	5.89
1917	0 59	8.49	23.97	4 16
1918	1.32	9.52	22.76	2.31
1919	2.2	10.06	20 87	7.40
1920	6 83	30 97	20.20	7.62
1921	17 91	37.37	21.08	5.97
1922	29.5	37.30	19.40	6 03
1923	40.81	25.95	17.78	12.68
1924	63.23	14.72	19.05	12.76
1925	73 14	11.78	19 03	8.10

(2) *Ardeal*

1919	8.37	13.54	14 48	7.98
1920	37 67	23.81	10 49	10.12
1921	56 0	24 07	9.64	13.31
1922	76 68	24 94	10 13	9 72
1923	81 09	16.93	14.05	10.24
1924	135.77	20.41	13 47	10 54
1925	122 34	9 93	21.26	7.91

(3) *Bukovina*

1922	5.614	21.3	22.4	3.6
1923	7.892	25.1	24.6	3.3
1924	13 123	25 0	26.1	2 1

¹ *Buletinul Muncii*, 1926.

RUSSIA

LEGISLATION

Legal Code of 15 November 1922

The Labour Code authorises the following benefits in kind:

First aid in the event of sudden illness;

Medical consultations at hospital dispensaries, polyclinics, etc.

Free clinical treatment;

Treatment at home,

Treatment of social diseases, by anti-tubercular and anti-venereal dispensaries, climatic and dietetic cures;

Convalescence and treatment in sanatoria, mechano-therapeutic and physio-therapeutic institutions;

Free supply of drugs, therapeutic aids and prosthetic apparatus, such as spectacles, crutches, etc. (Regulations of 4 March 1924).

Conditions under which Benefits are Granted

Every insured person is entitled to benefits in kind as from the day of his entry into an occupation which involves compulsory insurance and throughout the whole duration of his membership.

Legal Benefits

The patient must present himself for a consultation either at the medical office of his undertaking or at the dispensary, which will if necessary issue him a medical certificate, supply him with the necessary drugs or cause him to be treated in a hospital. An insured person who is unable to leave his residence must warn the visiting bureau, which will send a doctor on the same day if the notice is received in the morning, and the following day if notice is given in the afternoon. The doctor delivers a medical certificate and a prescription or causes the patient to be treated in a hospital. For attendance of various kinds, such a massage, bandages, etc., the visiting bureau sends a nurse to the patient's residence.

Dental treatment is given either in the hospitals which have a dental service or in a dental institute. Such attendance, however, is free only to the extent to which it is prescribed by a special committee. Insured persons who have lost 12 teeth or the state of whose teeth is prejudicial to their general health are entitled to free dentures. Nevertheless, when the disease of the teeth is due to an occupational cause (as is the case with workers in industries connected with lead and its derivatives, with mercury and its derivatives, with certain undertakings in the textile and paper industry, in industries connected with chlorine and its derivatives, in industries connected with nitric and sulphuric acids, in workshops where sugar is crushed) dental prosthesis is generally granted.

For special treatment the insured person must obtain a prescription from the director of the municipal health office. Any insured person who is found to be suffering from tuberculosis or from the premonitory symptoms of tuberculosis is entitled to treatment in special dispensaries.

Hospital treatment also takes place on a medical certificate; in particular, in the case of infectious diseases or serious accidents. In other cases of disease insured persons are received as and when vacancies arise, with priority over the members of families of the insured persons and over the general public.

Pharmaceutical assistance includes the free supply by municipal pharmacies of the drugs prescribed by the doctors.

Spectacles are supplied to insured persons belonging to one of the following professions: compositors, watchmakers, manufacturers of precision instruments, engravers, lace-makers, cutters, weavers, locksmiths, tanners, knife-grinders, moulders, draughtsmen, and copyists. Bandages are only given in the event of it being impossible to reduce a hernia by operation.

Insured persons appointed by a medical selection commissary are entitled to treatment in curative establishments and convalescent homes according to the number of free places reserved by the Social Insurance Department. The duration of the treatment may not exceed 3½ months and is on an average six weeks¹.

¹ *The Insured Persons' Guide.*

STATISTICS

Benefits in kind are administered by the Commissariat of Public Health, to which the Social Insurance Department pays directly the money earmarked for medical attendance.

In 1924-1925, the expenditure was 18.91 roubles per insured person, including dependants; in 1925-1926 it was 24.09 and in 1926-1927 it was 25.96 roubles; for 1927-1928 an expenditure of 27.87 roubles is provided for.

Besides the local authorities, the State also contributes to the cost of the medical treatment of insured persons; under this head an expenditure of 9 roubles per person is budgeted for in 1927-1928.

The following table shows the proportion of benefits in kind as compared with cash benefits. It is taken from the social insurance budget for 1924-1925¹.

THE PROPORTION OF EXPENDITURE ON SOCIAL INSURANCE PROJECTED
FOR THE PERIOD 1924-1925

Nature of expenditure	Percentage of resources allocated
	Per cent
Cash benefits in cases of invalidity	35.4
Expenses for layettes	5.6
Nursing bonuses	10.0
Funeral allowances	1.8
Medical attendance	43.0
Sanatoria	2.7
Rest homes	1.5

Official statistics showing the distribution of benefits in kind according to their nature are not available.

The cost of a consultation at a dispensary is calculated to be between 0.05 and 0.30 roubles; one day in a clinic between 0.90 and 2 roubles; the average price of a medical prescription at 0.15 roubles; and a stay of 15 days in a rest home or in a sanatorium at 25 roubles. A stay in a hospital costs 4 roubles a day, and a day's cure in a sanatorium at a health resort costs 5 roubles.

SERB-CROAT-SLOVENE KINGDOM

LEGISLATION

Act of 14 May 1922

Insured persons who fall ill are entitled to the following benefits in kind.

- Medical treatment;
- Drugs and therapeutic aids,
- Treatment in hospital under certain conditions.

Conditions under which Benefits are Granted

There is no qualifying period before an insured person becomes entitled to benefits in kind. Such benefits are granted as from the first day of incapacity to earn.

Medical attendance is due throughout illness up to a period of 26 consecutive weeks and thereafter during the period in which the patient receives sickness benefit.

¹ NEMTCHENKO. *Social Insurance in 1923-1924*, p. 82.

Pharmaceutical assistance is also due for 26 weeks but therapeutic aids may be granted after this period for so long as they are required (section 46, Nos. 1 and 2).

By a decision dated 13 July 1923 of the management committee of the Central Workers' Insurance Institution, the period during which medical and pharmaceutical assistance (and also sickness benefit) are granted has been prolonged as a form of additional benefit up to a period of 52 weeks for insured persons who during the previous year were members of an insurance fund for at least six months (cf Circular of the Central Workers' Insurance Institution, 31 August 1923)

Legal Benefits

Medical attendance can be given only by persons authorised to practice as doctors. In an emergency, however, when it has been found impossible to call in a doctor, other persons with sufficient experience may be entrusted with the duty of attending a patient.

The Act gives no details as to the insured person's right to treatment by a specialist. In practice in the industrial centres where the insurance institution maintains dispensaries, insured persons benefit by the attendance of specialists.

Pharmaceutical assistance includes drugs, baths, mineral waters, bandages, apparatus of all kinds, such as spectacles, crutches, artificial limbs, etc. It is granted only under medical prescription (section 45, No. 2)

Strictly speaking, treatment in hospital is not statutory benefit, since the insurance institution is not bound to grant it and cannot be compelled to do so by decision of the insurance court. But in certain given cases, it must grant hospital treatment to the extent which it is possible.

Hospital treatment is an alternative benefit, that is to say, the sickness benefit allowance ceases during the period of treatment. Nevertheless, members of the patient's family who do not earn their own living and live with him receive, during the period of treatment in hospital, half the sickness benefit which the patient would receive if he were not being treated in hospital (section 54, par. 5).

The insurance institution may grant treatment in hospital

(a) to a patient living with husband or wife or with members of his or her family, or in the case of a patient when adequate attention can be given him at home, but only if the patient consents to such treatment or if the disease is contagious or of such a kind as to need treatment in hospital, or when the patient does not follow medical advice and thus retards his own cure,

(b) to all other patients unconditionally.

A patient treated in hospital is entitled to free transport and to repayment of his travelling expenses (section 53).

Additional Benefits

The Act provides that medical treatment and drugs, together with sickness benefit, may be granted for more than 26 weeks up to a maximum period of one year (section 46)

It was mentioned above that by decision of the management committee of the Central Workers' Insurance Institute, dated 13 July 1923, the period of medical and pharmaceutical assistance may be extended from 26 to 52 weeks in the case of insured persons who have been members of an insurance fund for at least six months in the course of the previous year.

STATISTICS

The following table ¹ shows the value of benefits in kind granted, giving the total expenditure and the proportion of the various types of benefits in kind to the total cost of insurance.

¹ *Radnička Zastita*

COST OF BENEFITS IN KIND

(a) Cost per type of benefit in thousands of dinars (b) Percentage of the total cost of insurance

Year	Doctors' fees		Dentists fees		Drugs for insured persons		Hospital treatment for insured persons		Sanatoria and convalescent homes		Total	
	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
1923	11,196	7.03	806	0.51	19,183	12.05	11,502	7.22	3,850	2.09	46,537	28.90
1924	19,167	10.21	1,949	1.03	20,915	11.14	14,274	7.62	6,232	3.32	63,537	33.32
1925	22,007	10.78	4,647	2.21	22,921	10.00	17,727	8.45	8,976	4.28	76,278	35.72

SWITZERLAND

Cantons of Appenzell (Inner and Outer Rhodes), Basle Town, St. Gall, and Thurgau

Medical and pharmaceutical assistance are the main benefits of sickness insurance.

Compulsorily insured persons are entitled to medical treatment and drugs as from the day of their becoming members and as from the beginning of their illness. This right lasts for 180 days during a period of 360 consecutive days and, on the expiry of the first period of 360 days, for 90 days during a further period of 360 consecutive days in the two Sub-cantons of Appenzell and in the Canton of St. Gall, and for 360 days during a period of 540 consecutive days in the Canton of Basle Town. Medical treatment and drugs may, under certain conditions, be replaced by treatment and maintenance in a sanatorium.

CHAPTER V

MEDICAL ASSISTANCE FOR THE INSURED PERSON'S FAMILY

At its inception sickness insurance was rigidly modelled on the conceptions of private insurance, and provided benefits for insured persons in proportion to the payments made by them. The insurance benefits payable to insured persons were, if not alike, at least founded on a basis of equality, in that they took into account only the needs of the beneficiary, that is to say, the medical assistance required by his state of health, and the payment of sick benefits, fixed or variable, according as his contribution was fixed or variable. As far as the insured person's family was concerned, the system of benefits was not entirely free from a spirit of egoism, since, although the insurance scheme protected the working-class family by maintaining the head of the family in a condition to provide for their needs, it did not offer any help when the insured person and his family were affected by the illness of one of their members. Compulsory sickness insurance, social by definition but covering only the insured person, was to this extent individualistic.

Latterly, however, a new conception of insurance has appeared of a genuinely social character. The insured person is no longer placed in a different class from his family, and whereas the wage-earner, head of a family and household, is in no way freed of the obligation to provide for the moral and material welfare of his family, he now longer bears the whole weight of the responsibility. Insurance comes to his help when a member of his family is affected by an illness necessitating medical assistance; in a word, the worker's household, and not merely the worker himself, is protected against illness.

This extension of the scope of insurance is undoubtedly a very important thing, and the truth of this statement becomes evident when it is remembered that not only does the worker run the risk of falling ill himself, but he is also liable to be handicapped at any moment by the illness of a member of his household. This risk is, of course, mainly of an economic character, as it is the head of the family who generally has to defray the cost of medical

treatment and drugs arising from such illness. Again, and this is even more important, the illness of a member of a worker's family may endanger the hygiene of the home, and so constitute a threat to the health of the worker and to his earning capacity. Nor is this risk confined solely to the insured person, as all the members of his family are to some extent bound to suffer materially and physically. The extension of medical assistance to the family of the insured persons is a blessing, not only for the insured person himself, who has no longer to meet the expense of medical treatment for his family, but also, and perhaps more particularly, for the whole family, which is thus assured of the necessary medical treatment. Again, this measure, which extends beyond the confines of the worker's family, is certainly the most efficacious which could have been taken to improve the health of the working classes, as it has brought the doctor to the bedside of the working classes, who are thus for the first time placed under medical supervision and beyond the reach of charlatanism.

Although the capital importance of family medical assistance has in no way escaped the attention of legislators, this assistance, albeit fairly widespread, is not yet general. In the present Chapter a study is made of the progress in the evolution of this form of insurance. The Chapter opens with an international survey of the regulations governing the provision of medical assistance for the family of the insured person, attention being drawn to the compulsory or optional character of the assistance granted, the classes of persons protected, and the nature and the extent of the treatment to which they are entitled. The second part of the Chapter is devoted, in accordance with the general plan of this study, to a concise analysis of the various national legislative measures concerning the protection of the insured person's family and to a summary of the more important results of their application.

§ 1. — International Survey of Family Medical Assistance

NATURE OF FAMILY ASSISTANCE

Even before the war, sickness insurance schemes, especially those in Central European countries, had introduced medical benefits for the dependants of insured persons. In virtue of provisions embodied in their constitution, insurance funds were

authorised to grant insured persons the right of medical assistance for members of their family, the first instance of the legal authorisation of such measures occurring in the Hungarian Act of 1907 on Workers' Sickness and Accident Insurance.

The movement for the introduction of family medical assistance grew in strength during the years following the war. In the belligerent countries the whole population — the younger generation in particular — had undergone great privations, the general state of health had suffered, and, more than ever before, the organisation of medical assistance for the masses had become a necessity. A large number of insurance schemes of comparatively recent birth, despite financial obstacles, have granted medical assistance to the dependants of insured persons. Others, again, have authorised those of their funds whose finances have been ably managed to introduce family medical assistance as an optional benefit.

The grant of medical treatment to the families of insured persons is compulsory for sickness insurance funds in Czechoslovakia, Hungary, Norway, Poland, Roumania, and the Serb-Croat-Slovene Kingdom. In these countries family medical assistance is a normal part of the system of benefits, and provides medical treatment for the greater part of the working classes. In certain other countries — for example, Lithuania and Portugal — family medical treatment is included as a compulsory benefit in the legislation which is to govern the general scheme of sickness insurance. In Germany, family medical assistance is nowadays compulsory under the miners' insurance scheme, and its inclusion in the general system of the Federal Insurance Code would appear to be only a matter of time. Similarly, in Austria, the Salaried Employees' Insurance Act and the Workers' Insurance Act obliges insurance institutions to provide medical treatment for the members of the insured person's family.

Besides those countries which have made family medical assistance compulsory or which have already included it in the general Act on sickness insurance, there are others that confine themselves to admitting this form of insurance as an optional benefit, which consequently only concerns those funds which have provided for it in their rules. In Germany, where the insurance scheme is defined by the Federal Insurance Code, Austria, France (Alsace-Lorraine), Latvia, and Luxemburg, the insurance funds have made wide use of this authorisation to grant free medical treatment, and sometimes free drugs, to the family of the insured person. In this

manner a large number of working-class families — in Germany alone more than 14,000,000 persons belonging to the working classes — enjoy medical treatment. In Bulgaria also the sickness insurance scheme may provide benefits in kind for the dependants of insured persons.

In Great Britain the position is peculiar. Medical treatment for dependants of insured persons is included in the additional benefits which the approved societies are authorised to grant from any surplus they may realise. But as a matter of fact this authorisation remains a dead letter, as hardly a single approved society has included the grant of family medical assistance in its constitution. This abstention, which must not be attributed to a general conviction that the need of medical treatment for working-class families is amply met by the measures already taken, is due to the difficulties encountered by the approved societies, which are not organised territorially and which are not responsible for the organisation of medical services for the insured persons, in organising medical assistance for the benefit of the family of the insured person.

BENEFICIARIES OF FAMILY ASSISTANCE

In the various schemes under which family medical assistance is compulsory, this form of benefit is granted to the near relatives of the insured person, who are members of his household, and for whose support he is entirely or mainly responsible. Members of his household are not entitled to this benefit if they are already entitled to treatment in virtue of their own insurance. Within these limits the circle of beneficiaries sometimes includes the husband or wife and the children under age of the insured person (Norway, Portugal, Roumania), and sometimes other relatives who have formed part of the insured person's household for a certain time, and who are dependent on him — e.g. the parents, grandparents, grandchildren, and brothers and sisters of the insured person (Austria, Czechoslovakia, Hungary, Poland, and the Serb-Croat-Slovene Kingdom). In those countries where the insurance institutions, while not being obliged, are authorised to introduce family medical assistance, it is generally left to the institutions to decide whether they will extend its benefits to the whole family or merely to the nearest relatives of the insured person. Where the insurance funds granting this benefit are particularly numerous, medical assistance extends with certain restrictions to all relatives

living in the household of the insured person who are entirely or mainly dependent on him for their existence.

EXTENT AND DURATION OF MEDICAL ASSISTANCE

It is desirable that the members of the insured person's family should be entitled to claim, when necessary, medical assistance of the same extent and duration as that granted to the insured person himself. It is obvious indeed that unless these benefits are satisfactory from every point of view, the various reasons for extending medical treatment to the family of an insured person (which include relieving him from the cost of the sickness of his relatives, curing the sick person, maintaining hygienic conditions in the home, and preserving him and the members of his family from infection) cannot be achieved. Hence the rule generally applied nowadays, with certain restrictions, that family medical assistance must include the necessary medical treatment and drugs such as are granted to the insured person himself.

The compulsory benefits included under family medical assistance include, in Austria, Czechoslovakia, Hungary, Poland, and the Serb-Croat-Slovene Kingdom, medical treatment properly so called, the supply of medicaments, therapeutic and surgical appliances, and, where necessary, dental treatment and treatment and maintenance in a hospital, sanatorium, convalescent home, and so on; in Norway, medical treatment, dental treatment, and, where necessary, treatment and maintenance in a hospital, etc. Although the same kind of medical treatment is provided for an insured person and members of his family alike, there are a certain number of restrictions in connection with additional benefits. For example, special forms of treatment, such as cures in spas and convalescent homes, may in certain countries be reserved exclusively for insured persons themselves. The duration of medical treatment is sometimes the same as that for insured persons (Austria, 78 weeks under employees' insurance; Czechoslovakia, one year; Norway, 26 weeks; Roumania, 16 to 26 weeks; Serb-Croat-Slovene Kingdom, 26 weeks and sometimes less; Austria, 26 weeks under workers' insurance; Lithuania, 13 weeks; Poland, 13 weeks).

When family medical assistance is merely an optional benefit, its scope and duration are determined in detail by the decision governing its introduction; it may include medical treatment

properly so-called and also the cost of drugs and hospital treatment.* It may be entirely free or partly charged to the insured person, and it may include consultations at the dispensary or the patient's domicile. Considerable latitude is thus given to institutions granting medical benefits. Although conditions vary according to the different funds, family medical assistance shows a tendency, once it has been introduced, to become more and more complete.

In concluding this Section, attention should be drawn to the growing importance which in some European countries is being attached to sickness insurance as a means of protection of the health of the working classes. This conception of sickness insurance, which has become very widespread during recent years, is converting it into the principal instrument of the movement to improve general public health.

§ 2. — Provisions of National Laws and Statistics

AUSTRIA

LEGISLATION

*Law of 30 March 1888: New Text Promulgated by
Order of 20 November 1922*

Medical assistance for the family of the insured person is an optional benefit which may be introduced by the rules of funds in favour of members of the household of persons compulsorily insured or of persons who voluntarily continue compulsory insurance. This form of insurance may include all benefits granted under sickness insurance, with the exception of the daily sick benefit, and extends only to members of the insured person's family who live with him permanently as members of his household, who are mainly supported by him, and who are not themselves compulsorily or voluntarily insured (section 9 *a*, subsections 1 and 2).

The Act authorises the Federal Minister of Social Administration to declare family insurance to be a compulsory benefit either generally or for particular districts (section 9 *a*, subsection 4).

According to the Workers' Insurance Act of 1 April 1927, medical assistance for members of the insured person's family is compulsory, and is granted for a period of 26 weeks, on condition that the illness shows itself during the affiliation of the insured person or during the period in which he is entitled to insurance benefits (section 46).

In virtue of the Salaried Employees' Insurance Act of 29 December 1926, medical assistance is granted not only to the insured person but also to his wife or husband and other members of the family, parents and grandparents living in his household and legally supported by him, and, in default of a wife, to the woman who has kept house for an insured person for at least eight months. Nevertheless, with the exception of the wife or husband, members of the family are entitled to medical assistance only when their illness occurs at least six months after the affiliation of the insured person to the insurance scheme. The right to medical assistance extends over a period of 76 weeks for the same illness, but this provision does not apply if medical treatment is given in a dispensary. Medical assistance includes medical treatment, the supply of drugs and appliances, and dental treatment in accordance with the rules of the fund (section 8).

STATISTICS

Official statistics on the application of the Act of 30 March 1888 do not specify the expenditure made in respect of family insurance

According to the report of the Regional Fund of Vienna for the year 1924, it would appear that the cost of family assistance was as follows:

Year	Per cent. of the total cost of benefits	Year	Per cent. of the total cost of benefits
1919	3	1922.	4
1920	4	1923	4
1921	5	1924.	4

BULGARIA

Act of 6 March 1924

The Social Insurance Act of 6 March 1924 provides that, within the limits of the sickness insurance moneys at the disposal of the Social Insurance Fund, medical assistance and drugs may be granted to the family of the insured person (section 38, note). No measures of application appear to have been taken

CZECHOSLOVAKIA

LEGISLATION

Act of 9 October 1924

Medical assistance for the members of the insured person's family is a compulsory benefit. On condition that they form part of the household of the insured person the following are considered as members of his family, the husband or wife, legitimate children, children from a previous marriage of the husband or wife, adopted children, and wards, under 17 years of age, and also older children, grandchildren, brothers and sisters, parents, grandparents and parents-in-law, provided that such have formed part of the insured person's household for at least six months previous to the occurrence of the illness necessitating medical assistance.

Medical assistance includes medical attendance and the supply of drugs and therapeutic appliances and is granted during incapacity to work for a maximum period of one year. In lieu of medical treatment the members of the insured person's family may be granted maintenance and treatment in a hospital.

STATISTICS

Although there is no reliable information on the number of persons actually covered by family medical assistance the cost of such insurance is shown in the following table

COST OF MEDICAL ASSISTANCE TO MEMBERS OF AN INSURED PERSON'S FAMILY
(BOHEMIA, MORAVIA, AND SILESIA) (IN CROWNS)

Year	Average cost per insured person	Cost as percentage of total expenditure
1922	31.42	9.63
1923	32.25	8.13

FRANCE (Alsace-Lorraine)**LEGISLATION***Social Insurance Code of 19 July 1924*

Medical assistance for the family of the insured person is an optional benefit. Section 205, par. 1, authorises the introduction in the rules of a fund of provisions granting medical treatment to members of the insured person's family who are not themselves insured.

STATISTICS

The number of sickness insurance funds granting medical assistance to members of the insured person's family increases yearly, as may be seen from the following table.

Year	Actual number of funds granting medical assistance	Percentage of funds granting medical assistance
1919	109	41
1920	120	47
1921	148	59
1922	166	67
1923	192	78
1924	204	83

GERMANY**LEGISLATION***Notification of the New Text of the Federal Insurance Code,
Dated 15 December 1924*

Medical assistance for the family of the insured person is an optional benefit, which is established by the introduction of special clauses in the rules of insurance institutions. Section 205 b, par. 1, of the Federal Insurance Code, provides that these rules may authorise medical assistance for those members of the insured person's family who are not entitled thereto in virtue of their own insurance.

This assistance may include medical treatment and the supply of drugs, and likewise of spectacles, trusses, and other minor therapeutic appliances, hospital or domiciliary treatment, maintenance in a convalescent home, and the supply of appliances to prevent lameness or deformity. Nevertheless, the insurance funds are not bound to grant all the various forms of medical assistance, and may limit themselves to granting medical attendance properly so called. On the other hand, pecuniary benefit may not be granted to members of the insured person's family unless as an indemnity in lieu of medical assistance.

Although according to the general provisions of the Federal Insurance Code medical assistance to the dependants of the insured person is an optional measure, it is compulsory in the miners' sickness insurance scheme in virtue of the Act of 25 June 1926. According to section 23 of this Act, insured persons who have been members of the regional mining corporation, or of a miners' sickness fund, for at least three months are entitled to medical assistance and hospital treatment for their wife or husband and children if these persons are not thereto entitled under the sickness insurance or accident insurance schemes. As far as the husband or wife and children are concerned, medical assistance is granted of the same character as for an insured person.

himself. As a rule one-half of the cost of drugs necessitated by the illness of the wife or husband and children is borne by the miners' sickness insurance scheme, but in certain cases the proportion of such expenses payable by the scheme may be as much as 70 per cent. For the purposes of the Act a child is taken to mean a legitimate or legitimised child, an adopted child, an illegitimate child living in the household of the insured person, or a grandchild, if such have been supported entirely or mainly by an insured person previous to their illness.

STATISTICS

Medical assistance for the family of the insured person is the most important additional benefit granted under the general system governed by the Insurance Code. Four-fifths of the funds have introduced it, and only funds of lesser importance do not apply it. It may be said that nine-tenths of the members of the insured persons' families (wife or husband, parents, sisters and brothers, grandparents, children and grandchildren), forming part of the household of the insured person, and maintained by him, are covered by the medical assistance granted by the sickness insurance scheme.

Official statistics do not give any precise information as to the number of members of insured persons' households entitled to medical treatment. According, however, to an estimate made by the Federal Statistical Office for the years 1914 and 1924, the number of such persons increased from 4,700,000 in 1914 to 14,300,000 in 1924.

Sickness funds fully appreciate the importance of family medical assistance as appears from the fact that since 1914, when 37.1 per cent had introduced this benefit, the proportion of funds granting it has risen to 62.7 per cent in 1921 and to 80.1 per cent. in 1924.

Almost all the funds introducing this benefit grant it gratuitously, while four-fifths grant drugs and hospital treatment as well. With but few exceptions, medical assistance is granted for a period of 26 weeks.

The following table shows the various benefits in kind introduced by the funds in favour of members of the insured persons' families for the years 1924 and 1925.

Nature and duration of benefits	Percentage of funds granting benefits	
	1924	1925
Medical attendance	81.2	85.3
For a maximum period of 26 weeks	78.9	82.8
For a period of from 26 to 39 weeks	0.9	1.2
For a period of from 39 to 52 weeks	1.4	1.3
Drugs	65.8	69.6
For a maximum period of 26 weeks	63.8	67.4
For a period of from 26 to 39 weeks	0.8	1.1
For a period of from 39 to 52 weeks	1.2	1.1
Therapeutic appliances	47.0	50.8
Treatment in hospitals, convalescent homes, etc.		
For a maximum period of 26 weeks	59.9	65.3
For a period of from 26 to 39 weeks	58.6	64.0
For a period of from 39 to 52 weeks	0.5	0.6
	0.8	0.7

GREAT BRITAIN

Act of 7 August 1924

The Third Schedule, on additional benefits, of the Act of 7 August 1924, mentions medical attendance for persons supported by the insured person among the benefits which may be provided at the option of approved societies.

According to reports on the application of sickness insurance and statements made by the Royal Commission, which during 1924 and 1925 was entrusted with the examination of the working of the health insurance scheme, the approved societies do not take advantage of the authorisation to extend medical assistance to members of the family of the insured person. It is stated that the reason for this abstention is to be sought, not in the fact that the members of the family are in receipt of medical assistance from other insurance schemes, but in the difficulties experienced by the societies in organising medical services for their benefit.

HUNGARY

LEGISLATION

Act No XIX of 6 April 1907

The Act of 1907 entitles the insured person to claim medical assistance and drugs for members of his family who form part of his household. The duration of this assistance, which was initially fixed at 20 weeks, was subsequently increased to 26 weeks by the Orders No. 4790 of 1917 and to one year by the Order No. 5400 of 1919. In principle, family assistance is identical in every way to that granted to the insured person himself. Certain differences however do exist in respect to supplementary benefits. For example, whereas the insured person is entitled to complete maintenance by the fund during a cure in a spa, a member of his family has only the right to such a cure without maintenance.

STATISTICS

The number of members of insured persons' families covered by family insurance is not shown in any official statistics, but according to calculations based on the membership of the funds, the number of persons affected would appear to be as follows:

Year	Number of members of the insured person's family	Index number
1919	840,765	100 0
1920	764,012	90 08
1921	899,147	106.9
1922	1,026,110	122.0
1923	1,063,563	126 5
1924	1,123,034	133 5

The statistics of the Central Workers' Fund of Budapest make no distinction between the expenses for medical assistance granted to the insured persons and that granted to members of their family.

LATVIA

Workers' and Employees' Insurance Code, Published in 1922 by the Codification Section of the Ministry of Justice

The sickness insurance funds are entitled to organise medical assistance in favour of the members of the insured person's family. The extent of this assistance is determined by their rules, but no fund may allocate to family assistance more than one-third of the total sum received during the course of any one year in contributions from the employers and workers (section 37).

LITHUANIA

Act of 23 June 1912

Family medical assistance is compulsory, and every sickness insurance fund is obliged to grant the necessary medical assistance to members of the insured person's family during a maximum period of 13 weeks. At the same time the stipulation is made that the total expenditure for pecuniary benefits and benefits in kind granted to the insured person's family must not exceed one-third of the total income from employers' and workers' contributions (sections 64 and 65).

LUXEMBURG

LEGISLATION

Social Insurance Code of 17 December 1925

Medical assistance for members of the insured person's family is an optional benefit. The rules may provide for medical attendance and the supply of drugs to members of the insured person's family who are not themselves covered by insurance (section 10, par. 6).

STATISTICS

Medical assistance for the family (wife and minor children) of the insured person is one of the most important of the benefits granted by the insurance institutions. This benefit may cover the whole or part cost of medical treatment, the supply of drugs, and other curative measures.

No indication is given by official figures of the number of persons covered by family insurance. During 1923 the medical services were wholly or in part free for the members of an insured person's family in four regional funds, grouping 22.17 per cent. of the total number of persons affiliated to the regional funds, and in 15 industrial funds, grouping 85.47 per cent. of the total membership of such funds. The supply of drugs is partially or wholly gratuitous in 4 regional funds with 16.14 per cent. and in 10 industrial funds with 70.11 per cent. of the total membership of the respective classes of funds. These figures show clearly that family medical assistance plays a more important rôle in the industrial funds than in the regional institutions.

In the following table the cost of medical treatment and drugs for members of insured persons' families is compared with the total expenditure for treatment and drugs and with the total benefit expenditure of the funds.

COST OF FAMILY MEDICAL ASSISTANCE COMPARED WITH TOTAL EXPENDITURE

Year	Cost of family medical assistance, as percentage of total expenditure for medical assistance		Cost of drugs for family as percentage of total cost of drugs		Cost of medical assistance and drugs as percentage of total expenditure	
	Regional funds	Industrial funds	Regional funds	Industrial funds	Regional funds	Industrial funds
1918	4.51	11.08	5.88	6.52	1.36	2.73
1919	4.01	14.75	5.95	6.27	1.65	4.31
1920	4.87	21.48	5.27	12.48	1.82	9.20
1921	4.35	24.63	5.30	21.24	1.72	12.13
1922	5.15	24.94	6.37	23.12	2.39	12.75
1923	4.10	25.25	6.54	23.10	2.32	14.15

NORWAY*Act of 8 August 1925*

Medical assistance for members of the insured person's family was included as a compulsory benefit in the original sickness insurance law of 1909. The members of the family, including the husband or wife, children and adopted children under 15 years of age dependent on the insured person for maintenance, are entitled in case of illness to free medical and dental treatment, but no provision is made for the supply of appliances such as spectacles and trusses (section 16, par. 1 B).

In lieu of medical treatment the district sickness funds are empowered to provide maintenance and treatment in a hospital, provided that this does not result in appreciably higher expenditure for the funds, or if the doctor dealing with the case declines to be responsible for domiciliary treatment (section 18, par. 1). Hospital treatment for the members of the insured person's family is limited to 26 weeks (section 19, par. 5, No. 2).

In virtue of the Act of 17 July 1925 (section 16, par. 1 B) the sickness funds may provide medical treatment for children and adopted children under 17 years of age in case of congenital disease, when the curing of the illness is of vital importance for the future of the child. This treatment is granted by the sickness fund of the district in which the person supporting the child is domiciled.

Official statistics give no indication regarding the number of persons covered by family sickness insurance or the cost of the benefits granted.

POLAND**LEGISLATION***Act of 19 May 1920*

All sickness insurance funds are required to provide medical assistance for members of the insured person's family. This assistance is granted to members of the compulsorily insured person's family who form part of his household and who are supported entirely by him out of his earnings, if they are not themselves liable to compulsory insurance, and do not voluntarily contribute to the sickness insurance scheme. Further, the wife and children of the insured person, who do not form part of his household but are supported by him, are also entitled to medical assistance conditionally on being domiciled in the area of the fund concerned.

The benefits granted include medical treatment, supply of drugs, dressings, spectacles, and other inexpensive medical appliances, the maximum period of treatment being 13 weeks for the one illness. The treatment granted to the members of the insured person's family differs from that provided for the insured himself only in one thing, namely, that its duration is extended to 26 weeks in the case of the insured person. The benefits also include, where necessary, treatment in a spa, treatment by a specialist, and dental treatment. Provision is also made for hospital treatment, where necessary, up to a maximum period of 13 weeks (section 33).

STATISTICS

The following statistics established by the Ministry of Labour and Social Insurance relating to the work of sickness funds during 1924 show the number of members of insured persons' families covered by family insurance on 1 January 1925:

District	Number of funds	Number of persons included under compulsory insurance	Number of members of their families	Members of family per compulsory insured person
Central	16	292,265	350,718	1.2
Eastern	2	21,943	21,284	0.97
Western	51	455,005	591,506	1.3
Southern	66	344,059	402,549	1.2
Upper Silesia	2	33,255	35,915	1.1
Total	137	1,146,527	1,401,972	1.2

The official figures for 1924 also give the following information on the amount of medical assistance granted to the insured persons and members of their families respectively.

MEDICAL ASSISTANCE GRANTED TO INSURED PERSONS AND THEIR FAMILIES
DURING 1924

(a) Number of cases treated per 100 insured persons (b) Number of cases treated per 100 members of families.

District	Number of funds	Treatment in dispensary or consulting rooms		Domiciliary treatment		Treatment by specialists		Hospital, etc., treatment	
		(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
Central	16	683.5	390.0	42.4	60.2	8.9	7.2	3.9	2.2
Eastern	2	604.4	400.7	25.6	66.9	2.6	4.2	7.4	6.9
Western	51	224.9	105.0	26.6	22.7	21.2	5.0	4.8	1.5
Southern	66	296.7	102.7	23.2	23.2	17.7	6.4	3.9	1.2
Upper Silesia	2	301.8	58.9	6.9	5.9	53.2	5.0	6.5	1.1
Total	137	372.8	178.9	29.2	32.4	17.6	6.0	4.4	1.7

The official figures do not distinguish between the cost of medical assistance for insured persons and that granted to members of their family.

PORTUGAL

LEGISLATION

Decree of 10 May 1919, No. 5636

Medical assistance for the family of an insured person is a compulsory benefit, and insurance institutions are required to grant medical assistance and drugs to the insured person's wife and children under 16 years of age, while these benefits extend to other members of his family if they are incapable of earning their living and are supported by him. As insured persons themselves only acquire the right to benefit three months after the payment of their first contribution, it is taken for granted that this period applies likewise to members of an insured person's family (section 28 a).

ROUMANIA

LEGISLATION

Act of 25 January 1912

In the former Kingdom and Bessarabia, the wife and minor children of an insured person are entitled to treatment in a dispensary and, where necessary, to domiciliary attendance, while drugs may be supplied to them at reduced prices or even gratis (section 122 of the Act of 1922).

In Ardeal members of the insured person's family who are not themselves insured are entitled to medical assistance and drugs from the sickness funds, this being also the case in the Bukovina.

SERB-CROAT-SLOVENE KINGDOM

LEGISLATION

Act of 14 May 1922

Medical assistance for the family of the insured person is a compulsory benefit. On condition that they do not earn their own living and that they form part of the household of an insured person, the following persons are considered as members of the family: wife, housekeeper, legitimate, illegitimate or adopted children, parents, grandparents, grandchildren, brothers and sisters (section 45, par. 5).

The benefits granted to the members of insured person's families include free medical attendance and the supply of drugs and necessary appliances. These benefits are granted for a maximum period of 26 weeks, but only when the insured person himself is entitled to claim benefits.

STATISTICS

Although official statistics do not give any information relating to the number of persons covered by family medical assistance, the expenditure in this connection is shown as follows in reports of the Central Institute of Workers' Insurance for the years 1924 and 1925

COST OF MEDICAL ASSISTANCE GRANTED TO MEMBERS OF INSURED PERSONS' FAMILIES DURING 1924 AND 1925

(a) Cost in thousands of dinars. (b) Cost as percentage of the total expenditure on benefits.

Nature of benefit	In 1924		In 1925	
	(a)	(b)	(a)	(b)
Medical assistance	1,956	1.4	2,873	1.35
Drugs	5,076	2.70	7,034	3.35

CHAPTER VI

MATERNITY INSURANCE

The various efforts made by the present generation to increase economic security and to secure a healthier mode of life for the human race would be vain if a progressive decrease in the birth rate were to result in failure to maintain the normal equilibrium between the old and the young. Previous to the war, this danger did not appear imminent; but the curves of population have fallen since then in most belligerent countries owing to a decrease in the excess of births over deaths; and in some of these countries the excess is now so slight that the population problem dominates all others.

Will society find itself powerless to deal with this problem? Will it be compelled to look on helplessly while an inevitable evolution takes place, or does it possess the means, on the contrary, of influencing the birth rate and reacting against its inadequacy? The history of industrial States shows that they have constantly been animated by the will to increase the birth rate and raise its standard. The problem has a twofold aspect: it is not sufficient merely to increase the number of births, it is still more essential to prevent children that have been born from dying prematurely, or leading a life handicapped by physical defects.

A summary of the main principles of eugenics which have received general acceptance, and whose application is intended for the protection of motherhood, would be beyond the scope of this enquiry. Our task is more limited in character, and only relates to the special needs of those mothers who are wage-earners.

Rest is indispensable to expectant mothers; and pregnancy can only follow its normal course and be attended with satisfactory results if proper pre-natal care is ensured; and this obviously implies abstention from work before confinement. A normal confinement will be facilitated by proper medical attention and care during pregnancy; while it is essential that mothers should be assisted by a doctor or midwife during and immediately after

confinement. The mother after her confinement obviously needs rest and care, and is consequently unfit for work for some time after that event; while the new-born infant also requires the care and presence of its mother, who should be able to feed and nurse it. The conditions under which newly-born infants are fed, and an opportunity for their mothers to submit them to periodical medical examination are essential features of any system of child welfare. Both in the interests of the mother and of the child all these requirements must be fulfilled.

All industrial States are conscious of these needs, as is shown by the decisions adopted by the International Labour Conference at its First Session at Washington in 1919 in this connection. In particular the Draft Convention concerning the Employment of Women before and after Childbirth contains a series of prohibitions, and defines certain rights in favour of women employed in industrial and commercial establishments:

- (1) Women are forbidden to work during the six weeks following their confinement.
- (2) They shall have the right to leave work on presentation of a medical certificate proving that they are likely to be confined within six weeks.
- (3) The employer is prohibited from giving a female worker notice of dismissal during the prescribed period of absence.
- (4) A female worker while absent from her work on account of pregnancy or confinement shall be paid benefits sufficient for the full and healthy maintenance of herself and her child.
- (5) She shall be entitled to free attendance by a doctor or certified midwife.
- (6) She shall in any case if she is nursing her child be allowed half-an-hour twice a day during her working hours for this purpose.

Although the regulations contained in the Draft Convention have not yet been embodied in all national legislations, the legitimacy and desirability of such rules is universally recognised; and they are tending more and more to constitute an international standard for the protection of motherhood in all countries. Female workers in industry and commerce are already prohibited from working after their confinement in the great majority of countries, and abstention from work for a certain period before confinement is also authorised. Benefits are also granted in conjunction with absence from work in respect of pregnancy and confinement for the

maintenance of the mother and child; and these are referred to in the Draft Convention. Any measure by which women are prohibited from working after their confinement, and are authorised to remain absent from work during pregnancy, must necessarily remain inoperative if female workers are unable to find some means of subsistence other than remunerative work during the period of inactivity. For this purpose, either the employer may be compelled by law to continue to pay the female worker her wages during the period of absence from work in consequence of pregnancy and confinement, or the benefits necessary for the maintenance of the mother and child may be defrayed out of the public funds, or, lastly, all benefits connected with motherhood may be granted by the sickness insurance system in force.

This last method has been adopted in all States with a properly organised system of compulsory sickness insurance. Funds are responsible for granting benefits to insured women during their confinements: they are entitled to free attendance by a certified midwife, and if necessary by a doctor, and they also receive cash benefits from the funds during the prescribed period of absence from work before and after confinement. In certain laws the sickness insurance funds are also liable for certain other benefits, and in these cases the insured receive a grant after confinement to cover the cost of a layette, and also receive a nursing bonus. Further, all compulsory sickness insurance laws provide that an insured person who has not recovered her health at the end of the prescribed period of absence shall be entitled to the medical attendance which her state of health necessitates.

The urgent need for special measures for the protection of motherhood, going beyond the mere prohibition to work, is shown by the fact that several countries, where no general system of compulsory sickness insurance prevails, have been compelled to establish a system of maternity assistance, or a special scheme of maternity insurance. A brief reference to the principal schemes of this kind will suffice.

In Australia, a Commonwealth law (the Maternity Allowances Act) provides that all mothers, whether they are wage-earners or not, shall receive a fixed allowance of £5 out of the public funds. In Denmark, women to whom the provisions of the Factory Act apply receive a grant for a period not exceeding four weeks after their confinement, on condition that the child is not separated from its mother. In Spain all female wage-earners receive an allowance of 50 pesetas. In France the Act of 15 July 1893 provides

that destitute women shall receive free medical attendance during their confinement, either at home or in hospital; while, on the other hand, every Frenchwoman whose means are inadequate and who habitually undertakes work for remuneration, either at home or elsewhere, is entitled, during the period of rest immediately preceding and subsequent to her confinement, and for not more than eight weeks, to a daily grant. Lastly, every Frenchwoman to whom the provisions of the legislation relating to women during their confinement apply receives an additional grant out of public moneys during the twelve months subsequent to her confinement, if she is nursing her child. A regular system of maternity assistance may therefore be said to have been established in the above countries. In Italy a special system of maternity insurance was instituted by the Act of 17 July 1910, under which all female workers employed in industrial undertakings, in return for their contributions, together with those of their employers, supplemented by a State grant, are entitled to an allowance not exceeding 100 lire in respect of their confinements.

The benefits to which insured women are entitled during confinement under the various systems of compulsory sickness insurance are described below. Provided they comply with certain conditions, the insured are generally entitled to the attendance of a doctor or certified midwife, and also receive an allowance in respect of the period of absence during pregnancy and confinement, together with a nursing allowance. The conditions under which maternity benefits are granted to insured are analysed in § 1 below.

The importance of maternity protection among the workers being fully realised, compulsory sickness insurance has not restricted itself to assisting the insured during confinement, and in many countries the benefits of the system are also extended to the wives or other female members of the family of the insured persons. The nature and extent of the maternity benefits granted to members of the insured's family are described in § 2; while the main provisions of national laws relating to maternity benefits are summarised in § 3, together with the statistics of the working of these measures.

§ 1. — Conditions for the Grant of Benefits

The extensive nature of maternity benefits has rendered it necessary to provide a legal qualifying period, which must be completed before the insured become entitled to benefit. Certain laws,

however, such as the Czechoslovak and Russian Acts, do not impose any qualifying period; while in the majority of other sickness insurance laws, though the insured only become entitled to cash benefits after the completion of the qualifying period, they are entitled to free medical treatment irrespective of the time during which they have been insured.

The qualifying periods vary in length between three and ten months, dating from entry into insurance; and the period in question must either immediately precede confinement, or have been completed without long interruption in the course of a longer period preceding confinement. Membership during three months confers a right to cash benefits in Esthonia, Hungary, Latvia, and the Serb-Croat-Slovene Kingdom. In Bulgaria a right to benefit is only acquired after an uninterrupted period of 16 weeks, immediately preceding confinement; whereas in Poland insured persons who during the 12 months preceding confinement were employed for at least four months in a capacity rendering them liable to compulsory insurance are entitled to cash benefits. The following general systems of sickness insurance provide a six months' qualifying period: Austria, France (Alsace-Lorraine), Germany, Japan, Lithuania, Luxemburg, and Roumania; but in Germany the conditions under which benefits are granted are stricter, for insured persons are entitled to benefits only if during the two years immediately preceding confinement they have been members of a sickness fund administered under the provisions of the Social Insurance Code or of the Federal Miners' Benefit Society for at least ten months altogether, of which six fell within the year immediately preceding confinement. The Swiss Federal Act provides for a nine months' and the Norwegian Act for a ten months' qualifying period; while in Great Britain and the Irish Free State only those persons who have been insured for at least 42 weeks, and in respect of whom 42 weekly contributions have been paid, are entitled to maternity benefits.

The qualifying period has in many instances been instituted for the benefit of insurance institutions, which are at liberty to waive this provision at will; while certain laws, on the other hand, authorise funds to impose stricter conditions in connection with the grant of maternity benefits. In Great Britain and the Irish Free State, however, the qualifying period for cash benefits is compulsory under the insurance laws and may not be waived. In Czechoslovakia, for instance, though no legal qualifying period is imposed, insurance institutions are empowered to lay down rules

providing that money benefits shall only be granted to persons who have been subject to compulsory insurance for at least six months during the twelve months immediately preceding confinement.

OBSTETRICAL ASSISTANCE

Most laws provide that assistance of this description shall be provided in kind, and that the funds shall furnish the insured with the medical attendance and the appliances necessitated by their state of health. These benefits include the attendance of a certified midwife, and if necessary, of a doctor, together with the medicines and other remedies required. Regulations of this kind, varying to some extent in detail, are in force in Austria, Bulgaria, Chile, Czechoslovakia, Esthonia, Germany, Hungary, Latvia, Lithuania, Poland, Roumania, Russia, the Serb-Croat-Slovene Kingdom, and Switzerland. In Norway, women are authorised during their confinement to take the necessary measures themselves, the cost of medical and other assistance being reimbursed by the fund in accordance with the scale laid down. In Great Britain and the Irish Free State, approved societies are empowered to furnish women during their confinement with the assistance of a doctor or certified midwife, or to procure their admission to a maternity home; but societies can discharge their legal obligations in this respect by the payment of a lump sum allowance for maternity needs, and in fact adopt this practice. A lump sum allowance intended to defray the cost of attendance by a doctor or certified midwife is also the practice in France (Alsace-Lorraine) and in Japan.

Funds are empowered in most countries, after obtaining the insured woman's consent, to arrange for her admission to a maternity home, or to have her nursed at home, and in that case the cash benefits payable are generally reduced by half.

ALLOWANCE DURING PREGNANCY

The insured are entitled under compulsory sickness insurance laws to a pregnancy allowance, in the period during which absence from work is authorised by law, on presentation of a medical

certificate establishing pregnancy. The period during which the allowance is payable must necessarily coincide with the time of absence from work; and this period is fixed at two months in the Serb-Croat-Slovene Kingdom; eight weeks in Russia; six weeks in Germany, Austria, Bulgaria and Czechoslovakia; four weeks in Hungary, Japan and Latvia; two weeks in Chile, Esthonia, France (Alsace-Lorraine), Lithuania, Luxemburg, Norway, and Poland.

The amount of this allowance varies between 50 and 100 per cent. of the basic wage rate, amounting to at least 50 per cent. in Chile, France (Alsace-Lorraine), Germany, and Luxemburg, to 60 per cent. in Japan and Poland, 66½ per cent. in Austria, Czechoslovakia, and Lithuania, and 75 per cent. in the Serb-Croat-Slovene Kingdom; while it may equal the amount to wages in Esthonia, Hungary, and Russia. In Latvia the allowance is equal to wages, and is never less than the average wage of an unskilled working woman.

ALLOWANCE DURING CONFINEMENT

Prohibition to work for remuneration during the weeks immediately following confinement necessarily entails the right to cash benefits sufficient for the maintenance of the mother and child under proper hygienic conditions, and insurance institutions are hable for paying this form of benefit under all compulsory systems of sickness insurance. The period during which an allowance of this kind is payable is fixed at a minimum of six weeks, in conformity with the provisions of the Draft Convention adopted by the First Session of the International Labour Conference in 1919, by 14 compulsory insurance laws. The period is fixed at two months in the Serb-Croat-Slovene Kingdom, eight weeks in Latvia and Russia, and six weeks in Austria, Bulgaria, Czechoslovakia, France (Alsace-Lorraine), Germany, Japan, Lithuania, Luxemburg, Norway, Poland and Switzerland.

In some of these cases the time during which allowance for confinement is paid depends on the time during which the pregnancy allowance was paid, since the aggregate period for both allowances cannot exceed eight weeks. This is the case for example in France (Alsace-Lorraine), Luxemburg, and Poland. Similarly in Hungary, the allowance for confinement is granted for the eight weeks immediately following that event; but the time during which it is paid is proportionately reduced if the allowance for pregnancy was paid

for more than four weeks. In Esthonia the period does not exceed four weeks and in Chile two weeks.

This form of benefit varies, as in the former case, between 50 and 100 per cent. of the basic wage; and the fraction of the wage granted as allowance for confinement corresponds to that constituting the allowance for pregnancy. Under certain laws, however, the allowance consists of a lump sum and does not depend on the rate of wages.

In some cases the allowance for confinement is supplemented by a grant intended to defray other expenses connected with that event and the cost of a layette. The German law, for instance, provides for a lump sum payment of 10 marks, to defray the expenses connected with confinement or the complications arising in connection with pregnancy; whereas in France (Alsace-Lorraine) an allowance of 30 francs is granted for expenses connected with confinement. The grant for the purchase of a layette provided by the Russian Code amounts to 50 per cent. of the normal monthly wages prevailing in the district, while in the Serb-Croat-Slovene Kingdom this grant amounts to fourteen times the daily basic wage.

NURSING BONUS

Sickness insurance is also liable for providing mothers who are nursing their children with a bonus intended to help the recipient and to provide a suitable diet. An allowance of this kind is payable, under the insurance system, during the 12 weeks subsequent to confinement in Austria, Czechoslovakia, France (Alsace-Lorraine) Germany, Hungary, Luxemburg; for 13 weeks in Lithuania; and for eight months in Chile and Latvia, and nine months in Russia. In Poland a nursing bonus is payable for 12 weeks after the date when the payment of the allowance for confinement expires, while in the Serb-Croat-Slovene Kingdom the period is fixed at 20 weeks after that date. The amount of bonus is fixed arbitrarily or consists of a fraction of the daily basic wage varying from one-eighth to one-half.

Insurance institutions are empowered to insert provisions in their rules for granting benefits other than statutory benefits or to increase the amount and extend the period during which statutory money benefits can be granted.

§ 2. — Maternity Benefits to Members of the Insured's Family (Family Benefits)

As soon as it was realised that sickness insurance had been established to protect the health of the wage-earner's household, it was apparent that this necessitated measures for improving the conditions under which the children were born. When it is possible to ensure that children are born and nursed under proper hygienic conditions, a great step will have been made towards securing better health for the next generation. Sickness insurance can contribute in a great measure to this result by granting maternity benefits to members of the insured's family. In some insurance laws the wives of the insured were at once included among the persons entitled to maternity benefits; while in other cases this result was eventually attained by progressively extending the categories of those entitled to the benefits, which were originally restricted to insured persons. Fourteen compulsory sickness insurance laws include the wives of the insured among the persons entitled to maternity benefits.

In most laws this form of benefit is compulsory; in Austria, Czechoslovakia, Germany, Great Britain, Hungary, the Irish Free State, Lithuania, Norway, Poland, Roumania, and the Serb-Croat-Slovene Kingdom, sickness funds are required, in all circumstances, to grant the minimum statutory benefits to the wives of insured persons. In other cases, in Esthonia, France (Alsace-Lorraine), and Luxemburg, for instance, benefits of this kind remain optional; but all funds are empowered to draw up rules for this purpose. The number of funds which in practice grant maternity benefits to the wives of the insured is steadily increasing.

PERSONS ENTITLED TO BENEFIT

Family benefit is intended mainly for the wives of insured persons; it is a statutory benefit for wives (to the exclusion of other members of the insured's family) in Czechoslovakia, Esthonia, France (Alsace-Lorraine), Great Britain, Hungary, the Irish Free State, Lithuania, Luxemburg, Norway, and Roumania. Some laws provide for extending this form of benefit to other members of the insured's family, namely, daughters, granddaughters, and

sisters if they are dependent on the insured and are members of his household. Such extension is compulsory according to the provisions of the Austrian, German, and Polish laws, while the Czechoslovak and Roumanian Acts authorise it as an additional benefit.

NATURE OF FAMILY BENEFITS

In all countries where these benefits are compulsory they include free attendance by a certified midwife, and if necessary by a doctor, together with medicines, etc., on the same conditions as enjoyed by the insured. In Great Britain and in the Irish Free State, however, approved societies can discharge their obligation in this respect by the payment of a lump sum.

In some cases medical assistance is supplemented by cash benefits and in this case the benefits may include, in addition to obstetrical assistance, a lump sum allowance in connection with confinement, as in Norway, or a nursing allowance as in Poland. In some other countries, for instance, in Austria, Germany and the Serb-Croat-Slovene Kingdom, the members of the insured's family are entitled, in addition to obstetrical assistance, to a periodical allowance during confinement and, if necessary, a nursing bonus. In this case the only difference between the insured and members of the family consists in the fact that the former are entitled to higher benefits than the latter.

§ 3. — National Legislation and Statistics

AUSTRIA

LEGISLATION

*Act of 30 March 1886, Amended Text (Promulgated
by the Order of 20 November 1922)*

Benefits for Insured

No qualifying period is imposed before the insured become entitled to maternity benefits, funds may provide in their rules, however, that benefits of this kind shall only be granted to lying-in women who have been in an occupation rendering them liable to insurance for at least six months in the course of the 12 months immediately preceding the date of confinement (section 9c (5)).

Statutory benefits include.

(a) Benefits in kind, which comprise free medical attendance, including attendance at childbirth and the services of a midwife, as well as the necessary medicaments and other therapeutical requisites

(b) A periodical allowance equal to the daily sickness benefit, which is granted throughout the period of incapacity for work up to six weeks preceding and following confinement.

(c) A nursing bonus, amounting to half the sickness benefit. This is granted to lying-in women who nurse their infants themselves, irrespective of any sickness benefit or maternity benefit which they may receive, until the conclusion of the twelfth week following confinement (section 6, (1), (3), and (4)).

Properly qualified nurses may be placed at the disposal of women who are confined at home, with their consent, they may also, with their consent, be nursed in a maternity home or similar institution, in which case the cost of nursing is deducted from the cash benefits payable. The rules of the fund may also provide for extending the period during which the nursing bonus is paid to not more than 26 weeks

Family Benefits

The rules of the fund may give its compulsorily insured members a claim to maternity benefits in respect of members of their families (family insurance).

Family insurance includes all benefits granted by the fund, with the exception of the cash sickness benefit; but only members of the insured's family, who are neither subject to compulsory insurance or are themselves voluntarily insured, and who belong to the same household as the insured and are mainly supported by him, are covered by this form of insurance (section 9a, (1) and (2)).

The Workers' Insurance Act of 1 April 1927 and the Employees' Insurance Act of 29 December 1926 contain provisions under which more extensive maternity benefits may be granted. Under the former Act, insured persons who have been in an occupation rendering them liable to insurance for at least 26 weeks in the course of the last 12 months immediately preceding the date of confinement, or have been in receipt of sickness benefit or unemployment benefit during that period, are entitled to benefits in respect of pregnancy and confinement equal to the cash sickness benefit payable during six weeks before and six weeks after confinement, on condition that they abstain from all remunerative work during that period. The benefits in respect of pregnancy and confinement payable to members of the insured's family during the same periods amount to half the sickness benefit to which the insured themselves would be entitled in the event of sickness. The nursing bonus payable to insured women, or to the wives of insured persons, during the nursing period, not exceeding the 12 weeks immediately after confinement, amounts to half the sickness benefit, and this bonus may be granted conjointly with benefit in respect of confinement, or sickness benefit. Rights to benefits in respect of pregnancy or confinement, or to the nursing bonus, are suspended while the recipient is being nursed in a hospital or other similar institution at the expense of the fund (section 45). The Act of 29 December 1926 provides that the daily benefit payable to insured persons and their wives shall not exceed 3.75 schillings; it is payable during a period of six weeks following confinement in all cases, and during 12 weeks after confinement if the recipient is nursing her own child. Further, a lump sum bonus of 120 schillings is granted in respect of every newly-born child (section 13).

STATISTICS

The statistics published by the Ministry of Social Administration merely indicate the absolute and relative numbers of confinements in respect of which benefits were paid under sickness insurance, and the number of lying-in days per insured woman.

ABSOLUTE AND RELATIVE NUMBER OF CONFINEMENTS AND LYING-IN DAYS
IN RESPECT OF WHICH BENEFITS WERE GRANTED

Year	Number of confinements in respect of which benefit was granted	Number of confinements per 100 insured women	Lying-in days for which benefit was granted per insured woman
1915	10,881	3 28	0.92
1916	9,702	2.54	0.68
1917	9,104	2 24	0.77
1918	7,361	2.15	0 85
1919	7,407	2 85	1.11
1920	10,234	3.24	1 36
1921	10,333	3.00	1 31
1922	13,610	3 23	1.34
1923	13,097	3 20	1.35
1924	14,838	3.27	1.41
1925	15,684	3 46	1.41

BULGARIA

Act of 6 March 1924

Pregnant and lying-in women are entitled to benefits, provided they have paid their membership contributions for not less than 16 consecutive weeks before the period of confinement.

The beginning of the period of confinement must be attested by a certificate from the medical practitioner of the fund. A mistake of the medical practitioner in fixing the date of the confinement does not disqualify an insured woman from receipt of the benefit prescribed (section 21).

The statutory benefits include:

- (a) obstetrical assistance;
- (b) cash benefit payable during a certain period not exceeding 12 weeks including six weeks before and six weeks after confinement.

There are no provisions relating to a nursing bonus; but during a period of six months after her confinement every mother nursing her child must be granted two half-hour breaks a day, one in the morning and the other in the afternoon, without deduction from her wages (section 21, par. 5).

A woman must not be dismissed during pregnancy or confinement on account of her pregnancy, nevertheless if she is sick for more than six weeks in consequence of her confinement, she may be dismissed and treated as a sick person at the expense of the fund in accordance with the general provision (section 21, par. 6).

CHILE

Act of September 1924; Text as Promulgated by Decree No. 34 of 22 January 1926

Benefits for Insured

Maternity benefits are granted to lying-in women who have paid their insurance contributions for a minimum period of seven months (section 22, par. 1).

These benefits include: medical attendance for insured women during pregnancy, at the confinement, and during the period following the confinement, and also an allowance equal to 50 per cent. of the wage of the insured person during a fortnight before and after childbirth, and equal to 25 per cent in the succeeding period until the weaning of the child, if it is nursed by the mother. This period shall not exceed eight months (section 15 (c)).

Family Benefits

Insured persons who desire to extend to their families the benefits of medical attendance and drugs must pay every week to the competent fund a supplementary contribution amounting to five per cent. of their weekly income, wage, or salary. For this purpose the following persons are deemed to be members of the family of the insured person: his or her wife or husband, legitimate children, illegitimate children legally recognised, and in general all persons whom the insured person is legally bound to maintain. Nevertheless, these persons are not entitled to benefits unless they live with the insured person at his expense (section 13).

CZECHOSLOVAKIA

LEGISLATION

Act of 9 October 1924

Benefits for Insured

As a general principle, no qualifying period is required before insured persons become entitled to maternity benefits. Sickness insurance funds are, however, empowered by the Act to insert rules in their constitutions providing that the various benefits "shall not be granted to pregnant and lying-in women unless they have been liable to insurance for at least six months out of the 12 months immediately preceding the confinement."

On the other hand, a voluntarily insured person is not entitled to any benefits in respect of pregnancy or confinement if she was pregnant or had been confined at the date when she became insured (sections 104c, and 251, subsection 3).

Maternity benefits include:

- (1) The free services of a midwife, and, if necessary, of a doctor (attendance in confinement): independently of confinement, i.e. approximately ten days after confinement, an insured woman becomes entitled to the same medical benefits as other insured persons if her state of health requires it. The insured is also entitled to the services of a midwife or of a doctor in the event of a miscarriage.
- (2) Cash benefit equal to the cash sickness benefit, which amounts to approximately two-thirds of the daily basic wage, for six weeks before and six weeks after the confinement, provided the insured woman is not otherwise entitled to sickness benefit and refrains from all remunerative work: an insured woman is not, however, required to be incapacitated from all work, and right to benefit is not lost by reason of any household work performed by her.
- (3) A nursing bonus, equal to one-half the sickness benefit, i.e. one-third of the daily basic wage, to mothers who nurse their children themselves until the end of the twelfth week after their confinement. The nursing bonus is granted in addition to the lying-in benefits, so that the mother is in receipt of benefit equal to the daily basic wage during six weeks following confinement (section 95, II).

Instead of arranging for the insured to be attended by a midwife or doctor, and granting cash benefit, insurance institutions are authorised to treat insured women in public hospitals, and during the period the insured remains in hospital, half the sickness benefit is paid to members of her family (section 149, subsection 3).

Further a sick person who remains at home for treatment may be provided with a trained nurse, and a lying-in woman may be placed in a lying-in home or similar institution subject to her consent. In that case, not more than half the sickness benefit, including the lying-in benefits and nursing bonus above mentioned, may be applied to defray these expenses (section 152).

The nursing bonus may be granted by way of additional benefit until the completion of the twenty-sixth week after confinement (section 105 (f)).

Family Benefits

The wives of insured are in all cases entitled to family insurance benefits. The right to these benefits is not acquired until the end of a period of four weeks reckoned from the day on which the insured person became liable to insurance (section 97, subsection 3).

Family insurance benefits include the free services of a midwife, and, if necessary, of a doctor. They are also granted to the wife of an insured person, even if her husband dies during the nine months immediately preceding the confinement (section 95, II).

The Act also provides for granting as family insurance benefits, in the form of additional benefit.

- (1) A sum, not exceeding half the cash sickness benefit to which the insured is entitled, to pregnant and lying-in women, who are members of the family of the insured, for a period not exceeding six weeks before and six weeks after confinement.
- (2) A nursing bonus for a period not exceeding 26 weeks to members of the family of an insured person at a rate not exceeding a quarter of the cash sickness benefit to which the insured would be entitled (section 105, subsection 1, e, f).

STATISTICS

Number of Confinements in Respect of which Benefit was Granted

The following tables indicate the number of confinements in respect of which benefit was granted per 1,000 insured persons, and the average length of the confinement, for Moravia and Silesia, on the one hand, and for Slovakia and Sub-Carpathian Russia on the other.

NUMBER OF CONFINEMENTS PER 1,000 INSURED AND AVERAGE LENGTH OF CONFINEMENT IN BOHEMIA, MORAVIA, AND SILESIA

Year	Number of confinements per 1,000 insured (men and women)	Average length of confinement in days
1919	19	56 04
1920	18.8	57.98
1921	14.5	47 30
1922	9.6	43.39
1923	16.7	55 25
1924	15.8	55 69

NUMBER OF CONFINEMENTS PER 1,000 INSURED AND AVERAGE LENGTH OF CONFINEMENT IN SLOVAKIA AND SUB-CARPATHIAN RUSSIA

Year	Number of confinements per 1,000 insured (men and women)	Average length of confinement in days
1923	12.6	41.17
1924	8.2	61.69

Cost of Maternity Benefits

The aggregate cost, and the cost per insured, of maternity benefits are indicated in the following tables.

COST OF MATERNITY BENEFITS IN BOHEMIA, MORAVIA, AND SILESIA

Year	Total cost of maternity benefits (in thousands of crowns)	Average cost per insured (in crowns)
1922	60,520	28 3
1923	52,870	24 4
1924	52,993	22 4

COST OF MATERNITY BENEFITS IN SLOVAKIA AND SUB-CARPATHIAN RUSSIA

Year	Total cost of maternity benefits (in thousands of crowns)	Average cost per insured (in crowns)
1920	963	3 0
1922	5,997	16 3
1923	5,266	17 2
1924	5,726	17 4

ESTHONIA

LEGISLATION

*Act of 23 June 1912**Benefits for Insured*

Women are only entitled to cash benefits if they have been members of a fund for at least three months before confinement (section 312).

The qualifying period for female workers and employees in State undertakings is only six weeks.

Maternity benefits include:

- (1) Free medical attendance, together with drugs, dressings and other therapeutical requisites, and, if necessary, treatment in a hospital or maternity home.
- (2) Lying-in benefits, varying from 50 to 100 per cent. of wages, for a period of two weeks preceding and four weeks following confinement (section 312).

Family Benefits

Family benefits in connection with confinement are optional; and all funds may grant benefits to the wives of insured persons at the time of their confinement, provided not more than one-third of the aggregate contributions paid by employers and workers in the course of the year are devoted to this purpose (section 299).

STATISTICS

Number of Confinements in Respect of which Benefit was Granted

The statistics furnished by the Esthonian Government show that the number of confinements since 1923 was as follows:

	1923	1924
Number of confinements in respect of which benefit was granted . . .	288	308
Number of confinements per 1,000 insured persons (men and women)	19	19
Number of lying-in days for which benefit was granted	9,228	9,793
Average length of confinement . .	31.9	31.8

Maternity Benefits

The total cost of these benefits was as follows.

	1923 (In Estonian marks)	1924
Benefits to insured women . . .	896,581	1,264,846
Benefits to wives of insured . . .	721,100	782,777

FRANCE (Alsace-Lorraine)

LEGISLATION

German Social Insurance Code of 19 July 1911

Benefits for Insured

Insured women who have been insured against sickness with a sickness insurance fund, or with a miners' benefit society, for at least six months are entitled to maternity benefit (section 195).

Benefits include:

- (1) A lump sum of 30 francs towards the expenses of the confinements, together, if necessary, with a maximum grant of 20 francs for the expenses of the midwife, or as a contribution to the expenses of complications arising in connection with pregnancy
- (2) Cash benefit equal to the amount of the sickness benefit, i.e. half the basic wage, this benefit is granted during eight weeks, including six consecutive weeks immediately after confinement. Maternity benefit is not payable concurrently with sickness benefit
- (3) Nursing bonus, amounting to 75 centimes a day, every day, including Sundays and public holidays, until the end of the twelfth week after confinement, so long as the insured nurses her new-born child (section 195 of the Social Insurance Code, amended by section 7 of the Decree of 28 October 1920)

With the consent of the lying-in woman, the fund may grant treatment and maintenance in a maternity home instead of maternity cash benefits or attendance and treatment by home nurses, and deduct every day not more than half the maternity cash benefit (section 196).

On the other hand, the rules of the fund may provide that attendance by a midwife, or medical treatment, together with all medicines, etc., required in the event of confinement, and the attendance of a midwife or the medical attendance in case of complications arising in connection with pregnancy may be substituted for the grant of 30 francs intended to meet the expenses of confinement and the grant of 20 francs as a contribution to the expenses of the midwife or the medical expenses relating to complications arising in connection with pregnancy (section 8 of the Decree of 28 October 1920)

If hospital treatment is granted to a lying-in woman who has hitherto been maintained wholly or mainly out of her earnings, a cash benefit is paid to the relatives (sections 196 and 186)

The rules may provide that a pregnant woman who has been a member of the fund for not less than six months and becomes incapable of work in consequence of pregnancy shall be granted pregnancy cash benefit equal to sickness benefit for not more than six weeks in all. Further, the rules may provide that lying-in benefits shall be granted until the expiration of the

thirteenth week after confinement, and that the nursing bonus may be increased to one-half the amount of the sickness benefit and paid until the expiration of the twenty-sixth week following confinement (sections 199 and 200, amended by section 10 of the Decree of 29 October 1920)

Family Benefits

Family benefits in connection with confinement are optional; and funds are authorised, under section 205, to grant maternity benefits to the wives of insured persons who are not themselves subject to compulsory insurance.

STATISTICS

Number of Confinements in Respect of which Benefit was Granted

The following table shows the absolute and relative number of confinements in respect of which benefit was granted by sickness funds.

NUMBER OF CONFINEMENTS IN RESPECT OF WHICH BENEFIT WAS GRANTED
BY SICKNESS FUNDS

Year	Number of confinements in respect of which benefit was granted, including confinements of wives of insured persons	Number of confinements per 1,000 insured women
1919	3,820	42.5
1920	6,843	64.7
1921	8,603	78.0
1922	8,242	68.6
1923	12,761	99.2
1924	11,183	82.2

Cost of Maternity Benefits

The absolute and relative cost of maternity benefits are indicated in the two following tables, which show lying-in benefit and nursing bonus, on the one hand, and the cost of the attendance of a midwife and hospital treatment on the other.

TOTAL COST AND COST PER INSURED WOMEN OF LYING-IN BENEFITS, INCLUDING
NURSING BONUS

Year	Total cost of lying-in benefits including nursing bonus	Cost per confinement	Average cost per insured woman
	Francs	Francs	Francs
1919	396,669	103.9	1.16
1920	914,986	133.7	2.37
1921	1,603,863	186.4	4.10
1922	1,629,118	197.7	3.94
1923	1,880,512	147.4	4.28
1924	1,986,351	177.6	4.52

TOTAL COST AND COST PER INSURED WOMEN OF THE ATTENDANCE BY A MIDWIFE
AND HOSPITAL TREATMENT

Year	Total cost of the attendance by a midwife and hospital treatment	As a percentage of the total cost of benefits in kind	Average cost per insured woman
	Francs	Francs	Francs
1919	271,466	2.37	0.80
1920	483,033	2.25	1.25
1921	712,474	2.92	1.82
1922	886,241	2.98	2.14
1923	949,650	2.74	2.16

The number of funds which grant benefits to the wives of insured is steadily increasing, as shown by the following table

FUNDS GRANTING FAMILY MATERNITY BENEFITS

Year	Total number of funds	Funds granting maternity benefits to the wives of insured
1919	264	19
1920	257	26
1921	252	41
1922	247	55
1923	247	61
1924	246	62

GERMANY

LEGISLATION

Notification of the New Text of the Federal Insurance Code of 15 December 1924

Benefits for Insured

Insured women who have been insured against sickness under the federal insurance system, or with the Federal Miners' Benefit Society for at least ten months in the two years immediately preceding their confinement, and for at least six months in the year immediately preceding their confinement, are entitled to maternity benefits. The right to benefit subsists when an insured woman has ceased to be insured owing the pregnancy during the six weeks immediately preceding her confinement. The rules of a fund may, however, provide that a pregnant woman who has been a member of a fund for not less than six months and becomes incapable of work in consequence of pregnancy shall be granted pecuniary pregnancy benefit, equal to the sickness benefit, for not more than six weeks in all (sections 195*a* and 199).

Statutory insurance benefits include:

- (a) Benefits in kind, i.e. attendance of a midwife, drugs and appliances, and such medical treatment as may be required
- (b) A lump sum of ten marks towards the expenses of confinement and of complications arising in connection with pregnancy; if a confinement fails to take place, this shall amount to 6 marks only.
- (c) Daily maternity cash benefit equal to the amount of the sickness benefit, but not less in any case than 50 piennigs a day for four weeks

before the confinement and six weeks immediately afterwards. Benefit is also payable for two additional weeks before confinement on condition that the insured abstains from all remunerative work during that period, and that a medical certificate is forthcoming to the effect that the insured is likely to be confined within six weeks. Any error on the doctor's part as to the probable date of the confinement does not operate so as to prevent the insured from being entitled to benefit from the date of the medical certificate until the actual date of confinement. During the period preceding confinement, benefit becomes payable on the last day of each week, and not on the day of confinement. Sickness benefit is not granted in addition to maternity cash benefit in respect of the period subsequent to confinement, and only half the maternity cash benefit is paid for any time after the confinement during which the lying-in woman works for remuneration. If a lying-in woman dies at her confinement, or during the period for which she is entitled to benefit, the remaining sums due as maternity and nursing benefit are paid to the person who undertakes the maintenance of the child, until the end of the period of payment as fixed by the rules (section 195 a, (1), (2), (3), (4) and (6)).

- (d) Nursing bonus, equal to half the sickness benefit, but not less in any case than 25 pfennigs a day until the end of the twelfth week after the confinement, so long as the insured nurses her child. The governing body of the fund may fix a maximum amount for daily nursing benefit. The rules of the fund, or the local supervisory authorities, may require the funds to draw the attention of recipients of nursing benefit to the desirability of making regular visits to institutions established for the purpose of giving medical advice and treatment to mothers and newborn children (section 195 a (4)).

With the consent of the lying-in woman, the fund may:

- (1) grant treatment and maintenance in a maternity home instead of maternity cash benefit;
- (2) grant attendance and treatment by home nurses and deduct for it not more than half the maternity cash benefit.

If hospital treatment is granted to an insured person who has hitherto maintained relatives wholly or mainly out of earnings, home benefit equal to half pecuniary sickness benefit shall be paid to the relatives (sections 196 and 186).

Additional benefits may be granted under the rules of the fund as follows:

- (1) The lump sum payable towards the expenses of the confinement, etc., may be increased to 25 marks.
- (2) The duration of maternity cash benefit may be extended to 13 weeks (section 195 b).
- (3) Maternity cash benefit may be fixed at an amount in excess of pecuniary sick benefit up to a maximum of three-quarters of the basic wage (section 195 b).
- (4) The duration of the nursing bonus may be extended to 26 weeks (section 195 b).

Family Benefits

Maternity benefit is also granted to the wife, daughters, step-daughters and adopted daughters of an insured person who are members of his household provided that:

- (1) they habitually reside in Germany.
- (2) are not themselves entitled to maternity benefit in virtue of their own insurance;
- (3) the insured person has been insured against sickness under the federal insurance system, or with the Federal Miners' Benefit Society for at least ten months in the two years immediately preceding confinement, and at least six months in the year immediately preceding confinement (section 205 a, (1), (2), (3)).

The benefits to which members of the insured's family are entitled include, like ordinary benefits, benefits in kind (attendance by a midwife, and if necessary treatment, drugs and appliances), a lump sum, maternity cash benefit, and nursing bonus. Maternity cash benefit is fixed at 50 pfennig a day, and nursing benefit at 25 pfennig a day. The rules of the fund, or the local supervisory authorities, may require the funds to draw the attention of recipients of nursing benefit to the desirability of making regular visits to institutions established for the purpose of giving medical advice and treatment to mothers and new-born children (section 205 a)

Both the maternity cash benefit and the nursing bonus may be increased by the rules up to half the amount of the sickness benefit in respect of the insured person

The periods during which maternity cash benefit and nursing bonus may be granted may moreover be extended to 13 and 26 weeks respectively

Sickness insurance funds receive a federal grant of 50 marks for each case where family maternity benefits are granted, by way of contribution to the cost of statutory benefits.

Persons insured under the provisions of the Federal Miners' Benefit Society are entitled to the same insurance benefits as those insured under the Federal Insurance Code.

STATISTICS

Number of Cases of Confinement in Respect of which Benefit was Granted

The following tables indicate the absolute and relative number of confinements in respect of which benefit was granted by funds for the funds administered under the federal insurance code.

ABSOLUTE AND RELATIVE NUMBER OF CONFINEMENTS IN RESPECT OF WHICH BENEFIT WAS GRANTED BY FUNDS ADMINISTERED UNDER THE FEDERAL INSURANCE CODE

Year	Absolute number of cases	Relative number of cases per 1,000 insured women
1923	701,072	41.3
1924	678,554	37.2
1925	746,781	40.0

Total Cost and Cost per Insured

The cost of maternity benefits has increased considerably since 1914, as indicated in the following table

COST OF MATERNITY BENEFITS

Year	Total cost of maternity benefits (in millions of Rmk.)	Cost per insured (in Rmk.)	
		Men and women	Women
1914	12,593	0.8	2.2
1924	36,185	2.1	3.3
1925	56,446	3.1	5.1

The cost of medical treatment, attendance by midwife and drugs is not indicated in the above table as expenses of this kind are included in the cost of benefits for sick persons. Further, a federal grant in respect of family

maternity benefits (which amounted to 10,000,000 marks in 1924 and 20,000,000 marks in 1925) has also been deducted.

The average cost of benefits per confinement in 1925 (1924) amounted to 76 (55) marks, i.e. to 126.2 (88) marks per insured woman confined and 45.4 (33.7) marks per confinement of a member of the insured's family.

GREAT BRITAIN

LEGISLATION

National Health Insurance Act of 7 August 1924

Only persons who have been insured for 42 weeks, and on whose account 42 weekly contributions have been paid, are entitled to maternity benefits. Moreover, if subsequently the number of insurance contributions paid in the course of the "contribution year" (July to July) preceding confinement is less than 26, and the arrears of contributions remain unpaid, the right to maternity benefit is suspended. The provision for the suspension of maternity benefits is not, however, applied to insured persons who are unable to obtain employment.

Maternity benefit consists of a cash benefit, in the form of a lump sum, payable on the confinement of the wife of an insured person, or of an insured woman. The amount of the benefit depends on whether both the husband and wife are insured, or the woman herself is a compulsorily insured person at the time of her confinement or is married or unmarried. A distinction must be made between the following cases.

The benefit payable amounts to 40s. in the case of a married woman whose husband alone is insured.

Where both the married woman and her husband are insured, two benefits of 40s. each are granted, one in respect of the husband's and one in respect of the wife's insurance; if however the husband is for any reason disqualified for benefit two maternity benefits are paid from the wife's insurance.

In the case of an insured woman who continues in her employment after marriage but is alone insured, two benefits of 40s. each must be paid in respect of her insurance.

The benefit amounts to 40s. in the case of an insured unmarried woman.

It will be noticed that a woman who has remained in employment after marriage and is still compulsorily insured is entitled to double benefit, whether her husband is insured or not.

Maternity benefits must in every case be used for the benefit of the mother and child. Approved societies are indeed empowered to grant maternity benefit either in money or in kind, but in fact societies which place the services of a doctor or certified midwife at the disposal of women during their confinement are comparatively rare, and the beneficiaries usually select their own doctor or midwife. Although the law anticipates that the beneficiaries will in all cases be attended by a doctor or midwife, the fact that recourse is not had to their services does not involve loss of right to benefit. If, however, the society to which the insured belongs can prove that failure to call in a doctor or midwife was intentional, and if the beneficiary is herself a member of the society, a fine may be inflicted for negligence. The Act also provides that a married woman who is herself insured shall refrain from remunerative work during the four weeks following her confinement.

In *Northern Ireland* similar provisions exist, subject to this qualification that if the number of insurance contributions paid during the "contribution year" preceding confinement was less than 26, the right to maternity benefit is not suspended as in Great Britain, but reduced by half, namely to 20s., provided that at least 17 weekly contributions have been paid on behalf of the insured (*Arrears Regulations, 1924*).

STATISTICS

The following tables show for Great Britain and Northern Ireland respectively the total cost of maternity benefit and the cost per insured.

COST OF MATERNITY BENEFIT IN GREAT BRITAIN

Year	Aggregate cost of maternity benefit (in thousands of £)	Cost per insured (men and women) (in £)
1914	1,367.9	0.10
1915	1,269.8	0.09
1916	1,220.9	0.08
1917	1,045.2	0.07
1918	1,009.2	0.06
1919	1,187.6	0.08
1920	1,924.6 ¹	0.13
1921	1,903.9 ²	0.13
1922	1,844.5	0.12
1923	1,748.5	0.12
1924	1,701.9	0.11
1925	1,703.9	0.11

¹ Maternity benefit was increased from 30s to 40s. as from 5 July 1920.

² Figures from 1921 onwards include additional benefits.

COST OF MATERNITY BENEFITS IN NORTHERN IRELAND

Year	Total cost of maternity benefit (in thousands of £)	Cost per insured (men and women) (in £)
1923	45,600	0.14
1924	44,750	0.14
1925	46,800	0.14

HUNGARY

LEGISLATION

*Act XIX of 6 April 1907**Benefits for Insured*

Insured women who have been members of a sickness fund for at least three months before confinement are entitled to cash benefit; no qualifying period is, however, imposed in connection with right to free medical treatment or the attendance of a midwife in the event of confinement.

Statutory maternity benefits include:

- (1) Attendance by a midwife, or medical treatment during confinement and convalescence (section 51).
- (2) Pregnancy benefit equal to the average wage prevailing in the wage class to which the insured belonged during the last four weeks of pregnancy, on condition that the beneficiary abstains from remunerative work.
- (3) Lying-in benefit, equal to the average wage, for a period of eight consecutive weeks after confinement. If pregnancy benefit is granted for a period of more than four weeks, the period during which lying-in benefit is granted is correspondingly reduced. Both pregnancy and lying-in benefits are only payable provided the insured abstains from remunerative work. On the other hand, the fact that the insured continues to receive her salary or wages does not necessarily involve suspension of right to benefit, and an insured woman who remains unfit for work after the expiration of the period when lying-in benefit is payable is entitled to sickness benefit throughout the period of

illness, but not exceeding one year from the date on which lying-in benefit ceases to be payable.

- (4) A nursing bonus for 12 weeks following confinement. Insured women who are unable to nurse their children themselves are entitled, in lieu of nursing bonus, to receive food corresponding to the amount of the nursing bonus. Insured women who are incapacitated from work while they are nursing their children are entitled to sickness benefit in addition to nursing bonus. An insured woman who abstains from work for remuneration while nursing her child, on account of sickness necessitating the care of the child's mother, is also entitled to the benefit of the above provision.

Instead of being nursed at home, lying-in women may be treated in a maternity home; and in that case hospital treatment is substituted for treatment at home, and pregnancy and lying-in benefits. An insured woman who requires hospital treatment may be placed in a maternity home at the expense of the fund; and in that event the expenses of hospital treatment are defrayed out of the pregnancy and lying-in benefits.

Family Benefits

Sickness funds are required to provide the members of the insured's family during their confinement with medical treatment, including medicines, etc., during a period of six weeks (Order 4790 of 1917).

STATISTICS

The following table indicates the average cost of the various maternity benefits paid by the sickness funds administered by the Central Workers' Insurance Institution

AVERAGE COST OF VARIOUS MATERNITY BENEFITS

(a) Average expenses per member, in crowns (b) Cost as percentage of total cost

Year	Lying-in benefit		Pregnancy benefit		Nursing bonus		Hospital treatment	
	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
1919	6 4	2.6	—	—	—	—	0.36	0.1
1920	9	2.1	—	—	—	—	0.51	0.1
1921	12	1.8	3 9	0 5	0.7	0.1	0.86	0.1
1922	36	2.0	13.8	0 7	7.5	0.4	6.8	0.4
1923	530	1.3	219	0.5	84	0.2	96	0.2
1924	8 957	1.6	3,484	0 6	3,565	0.6	2,125	0.4

IRISH FREE STATE

LEGISLATION

Act of 16 December 1911

Maternity benefits consist of a lump sum payment to the wife of an insured person or to an insured woman during confinement (section 8, 1 (e)).

The person entitled to benefit is the mother, whether she is herself insured or not; and the amount paid must in every case be employed for her benefit and that of the newly-born child. Approved societies are empowered either to grant pecuniary benefit or to provide medical treatment corresponding to the amount of pecuniary benefit. Societies in fact always grant pecuniary benefit.

The person entitled to benefit should select her own doctor or midwife. No other insurance benefits are payable during the period of four weeks following

confinement (section 8 (6)) The insured must have been insured for at least 42 weeks and have paid 42 weekly insurance contributions before becoming entitled to maternity benefit

The amount of maternity benefit payable differs if the husband of the lying-in woman is alone insured, or if she and her husband are both insured, or if the woman is married or unmarried, in this connection the rules are similar to those in the British Act.

The maternity benefits payable are reduced if less than 26 weekly insurance contributions have been paid in the course of the " contribution year " (July to July) preceding confinement, and in that event benefits which are normally 40s. are reduced to 20s, provided the number of contributions paid are not less than 17.

Statistics

The number of confinements in respect of which insurance benefits were paid was approximately 25,000, both in 1924 and 1925 The aggregate cost of maternity benefits was £51,952 in 1924 and £51,985 in 1925, equivalent to an average expenditure per compulsorily insured person of £12

JAPAN

Act of 22 April 1922

Benefits for Insured

An insured woman who gives birth to a child is entitled both to confinement benefit and to maternity benefit A qualifying period of 180 days in the course of the year immediately preceding confinement is imposed before the insured becomes entitled to benefit. If the insured has only been a member of a fund for 90 days, she is however entitled to receive one or other of these forms of benefit A woman who has ceased to be insured remains entitled to benefit, provided she is confined within 180 days from the date when insurance ceases (Act, section 50; and Ordinance, sections 82 and 84).

Confinement benefit is fixed at 20 yen; but is reduced to half when a lying-in woman is treated in a maternity home or is attended by a midwife (Ordinance, section 81). Maternity benefit is paid during 28 days before and 42 days after confinement and amounts to 60 per cent. of the daily remuneration; the period during which benefit is granted must not, however, in any case exceed the period during which the insured abstains from work for remuneration (Act, section 50, and Ordinance, section 60).

Insurance institutions are empowered to provide lying-in women with treatment in a hospital or maternity home, or with the attendance of a midwife; and in that case maternity benefit is reduced with due reference, however, to the number of persons who are dependent on the insured (Ordinance, section 81).

LATVIA

Sickness Insurance Code, 1922

Benefits for Insured

Only women who have been members of a fund for at least three months before the date of confinement are entitled to cash benefit in respect of maternity (section 51).

The maternity benefit comprises, on the one hand, attendance during confinement, including the free supply of drugs, dressings and other medical requisites and, on the other, cash benefit equal to the full wages of the insured, but at least to the average wages of an unskilled working woman, for a period of four weeks before and eight weeks after confinement. Pregnant women are only entitled to benefit before their confinement while they actually abstain from

remunerative work. Funds are entitled to suspend cash benefit to lying-in women if they resume work within eight weeks of their confinement (sections 38 and 51). If at the end of the eighth week following the confinement the insured woman is still incapable of work, she is entitled to sickness benefit for not more than 26 weeks (section 51, subsection 1).

The general meeting of the fund has the right to accord to members of the fund who become mothers a nursing bonus equal to one-fourth of their wages for the maintenance of the child up to the age of eight months (section 51, Note).

Family Benefits

The fund may grant to the wife of an insured person the confinement cash benefit and a nursing bonus; but it may not expend upon family benefits more than one-third of its annual income (section 37).

LITHUANIA

Act of 23 June 1912

Benefits for Insured

Insured women who have been members of a fund for at least six weeks preceding their confinement shall be entitled to lying-in benefit (section 54).

- (1) Maternity benefit comprises attendance during confinement, either at home or in a maternity hospital (section 23, par. 2);
- (2) Confinement cash benefit equal to sickness benefit, over a period of two weeks before and six weeks following confinement, which is not payable concurrently with sickness benefit (sections 54 and 55);
- (3) A lump sum of 50 *litas* intended to cover the cost of confinement (section 56, subsection 2, par. 4), and a nursing bonus amounting to one-half the pecuniary sickness benefit for a period of 13 weeks (section 56, subsection 3).

Pregnant women who have been members of a sickness fund for at least six months preceding their confinement are entitled, for a period not exceeding six weeks before confinement, to a special allowance, if their working capacity has been decreased by at least 50 per cent. (section 58, subsection 1).

Funds are empowered, instead of granting cash benefit and with the consent of the insured, to provide treatment in a maternity home, or nursing treatment at their own home (section 59).

Family Benefits

Wives of insured persons must be granted confinement benefits by the fund (section 64).

LUXEMBURG

LEGISLATION

Social Insurance Code of 19 December 1925

Benefits for Insured

Insured women who have been members of a fund for at least six months during the year preceding their confinement are entitled to lying-in benefits (section 12, subsection 1)

The above benefits include at least:

- (1) Periodical benefit, equivalent to sickness benefit, during eight weeks, six of which shall be subsequent to confinement. Confinement benefit must be granted without any interruption during the specified period; and is not payable concurrently with sickness benefit.
- (2) A nursing bonus, equivalent to one-quarter of pecuniary sickness benefit, during a period of 12 weeks (section 12, subsections 1, 2, 3).

The fund may, with the consent of the insured, substitute medical treatment and attendance in a maternity home for cash benefit. If the insured has a family wholly or mainly dependent upon her, cash benefit equivalent to half the sickness benefit is granted to members of that family. The fund may also, with the consent of the insured, authorise the latter to be nursed at home, in which case the lying-in benefits payable are reduced by one-third (section 12, subsections 4, 5, 6).

Rules of funds may provide for the grant of the following additional benefits:

To married women or to all insured women during their confinement, medical attendance or attendance by a midwife.

To pregnant women who are incapacitated from work by their pregnancy, maternity benefit equivalent to sickness benefit for a period not exceeding six weeks

To pregnant women, medical attendance or the attendance of a doctor or a midwife, if necessitated by her condition

A nursing bonus, not exceeding half the sickness benefit, until expiration of the twelfth week after confinement (section 13, subsection 1).

Benefits to the Wives of Insured

The rules of the fund may provide that the wives of insured shall be granted the same confinement benefits as insured women themselves. In the event of the death of the husband, being an insured person, such benefits may still be granted provided confinement takes place within nine months of the husband's decease (section 13, subsection 4)

STATISTICS

Statistics issued by the Department of Agriculture and Social Welfare give the following information regarding the cost of maternity benefit:

EXPENDITURE BY DISTRICT AND INDUSTRIAL FUNDS FOR MATERNITY BENEFITS

Year	Total cost of maternity benefits	Percentage of the total cost of benefits	Average cost per insured	
			Men and women	Women
	Francs		Francs	Francs
1913	12,990	0.27	0 30	4 17
1919	14,496	0.13	0 38	4 71
1920	18,176	0.17	0 47	5 45
1921	2,424	0.14	0 06	0.72
1922	2 832	0.11	0 06	0.75
1923	2.661	0.10	0 05	0 62

NORWAY

LEGISLATION

Act of 6 August 1915

Benefits for Insured

Lying-in benefits are granted to insured women who have been members of a sickness fund for at least ten months preceding the confinement; short interruptions during that period shall not be taken into consideration (section 16, subsection (1), A (d)).

Lying-in benefits comprise:

- (1) free attendance by a midwife, not including the cost of special diet; these expenses are paid by funds in accordance with the scale laid down for that purpose.
- (2) maternity benefit for six weeks, reckoned from and including the day of the confinement, together with the two weeks preceding it. Wives who are not wage-earners, or whose income does not exceed 100 crowns per annum, receive a lump sum of 30 crowns (section 16, subsection (1), A (d))

Women members of funds, or wives of members, may be given free treatment and maintenance in a maternity home instead of the ordinary maternity benefits (section 18, subsection 1, (2)). If a woman on her confinement refuses without good ground to conform to the decision of a local sickness fund as regards her entry into a maternity home, the fund may resolve that all benefit to herself or her family shall cease (section 18, subsection 2, (2)).

The rules of a local sickness fund may provide that midwives' maintenance shall be included in the free attendance by a midwife (section 16, B (2)).

While a woman is in a maternity home on her confinement, the maternity benefit is suspended, but the local sickness fund may grant to her family at home as much as 50 per cent. of this to provide the necessary support for the household (section 18, subsection 4).

Benefits to Wives of Insured

Insured persons who have been members of a sickness fund for at least 12 months immediately preceding their wife's confinement are entitled to family benefit (section 16, B). These benefits include attendance by a midwife (not including the cost of special diet for the wife who is not herself a member of the fund), together with a lump sum payment of 30 crowns. Instead of these benefits a local sickness fund may provide free treatment and care in a hospital provided the period of treatment in hospital does not exceed 15 days.

STATISTICS

Number of Confinements in Respect of which Benefit was Granted

The following table shows the absolute and relative number of confinements in respect of which benefit was granted by sickness funds.

NUMBER OF CONFINEMENTS IN RESPECT OF WHICH BENEFIT WAS GRANTED

Year	Total number of confinements	Number of confinements per 1,000 insured persons
1917	20 216	42.70
1919	22 550	41.52
1920	28 647	51.28
1921	27 228	49.97
1922	28,030	49.15
1923	28,519	49.28
1924	27,697	47.34

Cost of Maternity Benefits

The following table indicates the total cost, and the cost per insured, of maternity benefits, together with the percentage of the cost of these benefits to the total cost of benefits.

The above benefits include at least.

- (1) Periodical benefit, equivalent to sickness benefit, during eight weeks, six of which shall be subsequent to confinement. Confinement benefit must be granted without any interruption during the specified period; and is not payable concurrently with sickness benefit.
- (2) A nursing bonus, equivalent to one-quarter of pecuniary sickness benefit, during a period of 12 weeks (section 12, subsections 1, 2, 3).

The fund may, with the consent of the insured substitute medical treatment and attendance in a maternity home for cash benefit. If the insured has a family wholly or mainly dependent upon her, cash benefit equivalent to half the sickness benefit is granted to members of that family. The fund may also, with the consent of the insured, authorise the latter to be nursed at home, in which case the lying-in benefits payable are reduced by one-third (section 12, subsections 4, 5, 6).

Rules of funds may provide for the grant of the following additional benefits:

To married women or to all insured women during their confinement, medical attendance or attendance by a midwife

To pregnant women who are incapacitated from work by their pregnancy, maternity benefit equivalent to sickness benefit for a period not exceeding six weeks

To pregnant women, medical attendance or the attendance of a doctor or a midwife, if necessitated by her condition.

A nursing bonus, not exceeding half the sickness benefit, until expiration of the twelfth week after confinement (section 13, subsection 1).

Benefits to the Wives of Insured

The rules of the fund may provide that the wives of insured shall be granted the same confinement benefits as insured women themselves. In the event of the death of the husband, being an insured person, such benefits may still be granted provided confinement takes place within nine months of the husband's decease (section 13, subsection 4)

STATISTICS

Statistics issued by the Department of Agriculture and Social Welfare give the following information regarding the cost of maternity benefit:

EXPENDITURE BY DISTRICT AND INDUSTRIAL FUNDS FOR MATERNITY BENEFITS

Year	Total cost of maternity benefits	Percentage of the total cost of benefits	Average cost per insured	
			Men and women	Women
	Francs		Francs	Francs
1913	12,990	0.27	0.30	4.17
1919	14,496	0.13	0.38	4.71
1920	18,176	0.17	0.47	5.45
1921	2,424	0.14	0.06	0.72
1922	2,332	0.11	0.06	0.75
1923	2,661	0.10	0.05	0.62

NORWAY

LEGISLATION

Act of 6 August 1915

Benefits for Insured

Lying-in benefits are granted to insured women who have been members of a sickness fund for at least ten months preceding the confinement; short interruptions during that period shall not be taken into consideration (section 16, subsection (1), A (d)).

Lying-in benefits comprise:

- (1) free attendance by a midwife, not including the cost of special diet; these expenses are paid by funds in accordance with the scale laid down for that purpose.
- (2) maternity benefit for six weeks, reckoned from and including the day of the confinement, together with the two weeks preceding it. Wives who are not wage-earners, or whose income does not exceed 100 crowns per annum, receive a lump sum of 30 crowns (section 16, subsection (1), A (d)).

Women members of funds, or wives of members, may be given free treatment and maintenance in a maternity home instead of the ordinary maternity benefits (section 18, subsection 1, (2)). If a woman on her confinement refuses without good ground to conform to the decision of a local sickness fund as regards her entry into a maternity home, the fund may resolve that all benefit to herself or her family shall cease (section 18, subsection 2, (2)).

The rules of a local sickness fund may provide that midwives' maintenance shall be included in the free attendance by a midwife (section 16, B (2)).

While a woman is in a maternity home on her confinement, the maternity benefit is suspended, but the local sickness fund may grant to her family at home as much as 50 per cent. of this to provide the necessary support for the household (section 18, subsection 4).

Benefits to Wives of Insured

Insured persons who have been members of a sickness fund for at least 12 months immediately preceding their wife's confinement are entitled to family benefit (section 16, B). These benefits include attendance by a midwife (not including the cost of special diet for the wife who is not herself a member of the fund), together with a lump sum payment of 30 crowns. Instead of these benefits a local sickness fund may provide free treatment and care in a hospital provided the period of treatment in hospital does not exceed 15 days.

STATISTICS

Number of Confinements in Respect of which Benefit was Granted

The following table shows the absolute and relative number of confinements in respect of which benefit was granted by sickness funds.

NUMBER OF CONFINEMENTS IN RESPECT OF WHICH BENEFIT WAS GRANTED

Year	Total number of confinements	Number of confinements per 1,000 insured persons
1917	20,216	12.70
1919	22,550	11.52
1920	28,647	11.28
1921	27,228	10.97
1922	28,036	10.15
1923	28,549	10.28
1924	27,687	10.31

Cost of Maternity Benefits

The following table indicates the total cost, and the cost per insured, of maternity benefits, together with the percentage of the cost of these benefits to the total cost of benefits

COST OF MATERNITY BENEFITS (IN CROWNS)

Year	Cost of maternity benefits	Average cost per member (men and women)	As percentage of the total cost of benefits
1917	927,858	1.97	7.0
1918	1,185,550	2.29	5.1
1919	1,343,550	2.42	4.2
1920	1,819,707	3.26	5.4
1921	1,874,670	3.43	5.3
1922	1,940,200	3.40	4.8
1923	1,860,246	3.21	5.3
1924	1,803,383	3.09	5.0

The statistics issued by local sickness funds also show the average cost and the cost per member of certain maternity benefits granted in kind

TOTAL COST AND COST PER MEMBER (MEN AND WOMEN) OF CERTAIN MATERNITY BENEFITS GRANTED IN KIND (IN CROWNS)

Year	Treatment in a maternity home		Midwives' fees		Midwives' travelling expenses		Nurses' fees	
	Total cost	Cost per member	Total cost	Cost per member	Total cost	Cost per member	Total cost	Cost per member
1917	22,768	0.05	275,455	0.59	799	—	4,217	0.01
1918	30,060	0.07	366,385	0.74	2,039	—	7,118	0.01
1919	36,210	0.06	428,237	0.79	2,228	—	9,611	0.03
1920	75,508	0.13	617,009	1.10	3,230	0.01	10,015	0.01
1921	94,294	0.17	665,668	1.22	5,226	0.01	5,479	0.01
1922	118,082	0.20	694,415	1.22	5,052	0.01	12,779	0.02
1923	124,475	0.22	694,115	1.20	7,300	0.01	14,199	0.02
1924	129,874	0.23	678,085	1.16	4,756	0.01	9,949	0.02

POLAND

LEGISLATION

Act of 19 May 1920

Benefits for Insured

Only women members who during the 12 months immediately preceding the confinement have been employed for not less than four months in an occupation rendering them liable to insurance are entitled to maternity benefits. Voluntarily insured women members are not entitled to maternity benefits unless they have been members of the fund for not less than eight months before having recourse to its aid (sections 30, subsection 2, and 31)

Maternity benefits include.

- (1) The services of a medical practitioner and a midwife before, during and after confinement; this benefit is not subject to any restriction in time (section 30, subsection 1, a).

- (2) Maternity cash benefit, equal to the basic wage, during the whole period of absence from work, but for not more than eight weeks, of which not less than six must be subsequent to the confinement. If incapacity for work extends beyond this period, the fund shall grant benefits before or after the confinement in accordance with the general principles of sickness benefit (section 30, subsection 14 *b*, and subsection 3)
- (3) If they nurse their children, nursing bonus during the nursing period, but for not more than 12 weeks in all.

With the consent of the woman lying-in the fund may grant her:

In place of half the cash benefit, medical attendance and maintenance in a maternity home, treatment and attendance by a nurse, subject to a reduction of the cash benefit by not more than one-half (section 30 subsection 1 (4))

Family Benefits

Family benefits in connection with confinement are compulsory; and members of the family of a compulsorily insured person who live in the same household and are entirely dependent on his wages, but are neither liable to compulsory insurance nor voluntarily insured, namely, the wife, daughters, sisters and wards of the insured, are entitled to this form of benefit (section 33).

These benefits include: free medical attendance or attendance by a midwife during and after confinement, together with a nursing bonus equal to half the bonus granted to an insured woman while she is nursing her child, for not more than 12 weeks from the date of confinement (section 33, *b*, *c*).

STATISTICS

The average number of confinements per 100 insured women amounted in 1924 to 2.42 and in that year the average period during which pecuniary benefit was granted in respect of confinement amounted to 42.3 days.

PORTUGAL

Act of 10 May 1919

Benefits for Insured

A qualifying period of three months is imposed before the beneficiary becomes entitled to benefits in kind, while cash benefit only becomes payable six months after the payment of the first insurance contribution (section 28, (1), (2), and section 30 (1))

Insured women who comply with the conditions for granting benefit are entitled at their confinement either to treatment in a hospital or maternity home, or to medical treatment, including drugs, and to cash benefit for a maximum period of two months while they are incapable of work (section 33).

ROUMANIA

LEGISLATION

Act of 25 June 1912

Benefits for Insured

Women who have been members of a fund for at least 26 weeks and have paid insurance contributions during that period are entitled on their confinement to the following maternity benefits:

- (1) attendance by a midwife, or medical treatment including drugs, etc., these benefits are granted both under the Act in force in the territory of the former Kingdom and in Bessarabia and the provisions in force in Ardeal and Bukovina
- (2) maternity cash benefit for two weeks before and six weeks after confinement in the former Kingdom and in Bessarabia; during eight weeks in Ardeal, and for four weeks before and six weeks after confinement in Bukovina,

- (3) a nursing bonus payable during three months in the former Kingdom and in Bessarabia, and during twelve weeks from the date on which maternity cash benefit ceases to be payable in Ardeal.

Family Benefits

Members of the family of the insured who are not themselves insured are entitled to a free medical treatment, including drugs, from the sickness insurance institution.

Statistics

The following table shows the number and average length of confinements registered by sickness funds in the territory of the former Kingdom

NUMBER OF CONFINEMENTS AND AVERAGE LENGTH IN THE FORMER KINGDOM

Year	Number of confinements per 1,000 insured persons (men and women)	Average length in days
1912	34	42
1913	57	52
1914	60	52
1915	50	50
1916	56.6	49
1917	13.5	42
1918	14.9	35
1919	31.4	61
1920	21.9	60
1921	26.7	62
1922	23.1	71
1923	17.2	61
1924	28.5	70
1925	40.5	69

RUSSIA

Labour Code of 15 November 1922

Insurance Benefits

No qualifying period was imposed as regards insured women in connection with maternity benefit up till 9 May 1927. At present, however, the law requires a qualifying period of six months to be completed.

Women during their confinement are entitled:

- (1) to medical or other treatment in a maternity home or crèche. Pregnant women are entitled to one medical examination every two months during the first month of pregnancy, and subsequently to one examination a month. Pregnant women must be admitted to a maternity home or lying-in hospital one or two days before confinement. Women living by themselves or in unhealthy dwellings may be admitted to dwellings specially established for that purpose one month before the probable date of confinement, and may remain there one month after confinement. Newborn children suffering from illness may be admitted to crèches;
- (2) pregnancy and lying-in benefits, payable for 16 weeks in the case of female manual workers and 12 weeks in the case of female non-manual workers;
- (3) an allowance for the purchase of a layette, intended as a contribution to the special expenses on account of the new-born child, amounting to a sum varying between 16 and 30 roubles according to the district;

- (4) a nursing bonus, equivalent to one-fourth of the average monthly wages payable in the district, is granted for nine months after confinement. This payment is intended to provide to a mother who is nursing her child with the proper diet, or to defray the cost of feeding it.

SERB-CROAT-SLOVENE KINGDOM

LEGISLATION

Act of 14 May 1922

Benefits for Insured

A woman who cannot show she has been a member of an insurance institution for at least three months during the year preceding her latest affiliation to the institution is not be entitled to maternity benefit unless confinement has taken place after a continuous membership of three months (section 49).

Insured women are entitled to the following benefits at confinement:

- (1) The requisite assistance from a midwife, and medical attendance.
- (2) Maternity benefit, for two months before and two months after confinement, at a daily rate of three-quarters of the basic wage, amounting to 1 50 dinars per day in the lowest wage class and 36 dinars per day in the highest wage class. Benefit is not payable in respect of days during which the insured continues to work; and can be reduced if the patient refuses to conform to medical advice, thus retarding her recovery.
- (3) An allowance for the purchase of a layette amounting to 14 times the daily basic wage. This sum amounts to 28 dinars for the lowest wage class, and to 672 dinars for the highest wage class.
- (4) Nursing bonus, for insured women who nurse their children themselves for 20 weeks after the cessation of maternity benefit, at a daily rate of half the basic wage, but not more than 3 dinars. An insured woman who is medically certified as unable to nurse her child herself receives food for the child not exceeding in value the amount of the nursing benefit due to her, instead of the nursing bonus (section 45 (4)).

Lying-in benefit may be increased, in the form of additional benefits, to an amount not exceeding the basic wage; and the period during which they are granted may be extended to 12 weeks after confinement.

Family Benefits

Family benefits in connection with confinement are compulsory; and members of the insured's family who are not wage-earners themselves and belong to his household, are entitled:

- to the services of a midwife or to medical attendance
- to maternity cash benefit for four weeks before and four weeks after confinement, amounting to 1 50 dinars per day,
- to an allowance for the purchase of a layette amounting to 14 times the daily basic wage of the insured

The following shall be deemed members of the family: married or unmarried spouse; legitimate, illegitimate or adopted children, grandchildren, and sisters of the insured

STATISTICS

The following table indicates the total cost and the average cost of maternity benefits granted by the Central Workers' Insurance Institution.

DETAILED STATEMENT OF THE VARIOUS MATERNITY BENEFITS GRANTED BY
THE CENTRAL WORKERS' INSURANCE INSTITUTION

(a) Total cost in thousands of dinars. (b) Percentage of the total cost of insurance.

Description of benefits	1923		1924		1925	
	(a)	(b)	(a)	(b)	(a)	(b)
Lying-in benefits to insured	3,387	2 13	4,149	2 22	4,888	2 33
Lying-in benefits to members of the insured's family	—	—	1,213	0.65	1,145	0.55
Layette allowance to insured	6,537	4 11	1,441	0.60	1,544	0 74
Layette allowance to members of insured's family	—	—	7,802	4.16	8,569	4 09
Nursing bonus to insured	378	0 24	437	0 23	456	0 22
Cost of attendance by midwife for insured	1,006	0 63	358	0 19	450	0 21
Cost of attendance by midwife for members of the insured's family	—	—	1,373	0.73	1,815	0 87

SWITZERLAND

LEGISLATION

The Federal Act of 13 June 1911 provides that insurance funds shall treat confinement like an ordinary illness, and that mothers who have been members of a recognised fund for at least nine months, without an interruption exceeding three months in length, shall be entitled to benefit. The minimum benefits comprise either one or the other, or one and the other of the following: medical attendance including drugs, and a daily cash benefit of one franc. Benefits are payable during the six weeks following confinement; and in the event of the insured undertaking remunerative work while benefit is being paid, her earnings are deducted from the benefit. The fund pays a minimum nursing bonus of 20 francs for four weeks from the date when the daily cash benefit ceases to mothers who are nursing their children themselves (section 14).

The cantonal laws under which compulsory sickness insurance has been established therefore provide that funds shall pay certain maternity benefits, which shall not be less than those laid down in the Federal Act.

Appenzell, Outer Rhodes

Act of 30 April 1916

A woman who has been a member of a fund for nine months before her confinement (provided no interruption exceeding three months has occurred) is entitled to sickness benefit during six weeks; and the cost of attendance of a midwife, and, if necessary, medical attendance, must be defrayed by the fund. The nursing bonus is 20 francs when the mother nurses her child for ten weeks in all. For each further period of four weeks, the Canton grants an additional 20 francs.

Appenzell, Inner Rhodes

Order of 29 November 1920

Maternity benefits are similar to those provided for in Appenzell (Outer Rhodes) But the nursing bonus is fixed at 20 francs in conformity with the

Federal Act, and is payable to mothers who nurse their children themselves for four weeks subsequent to the period during which lying-in benefit is paid, namely, six weeks (section 15).

Basle Town

Act of 19 November 1914

Women who have been members of a recognised fund for at least nine months before confinement are entitled:

- (1) To free attendance by a midwife, and, if necessary, to medical attendance, together with drugs and dressings, or to medical treatment in a maternity home.
- (2) To a nursing bonus as provided by the Federal Act, namely, 20 francs, provided the mother is still nursing her child at the end of the tenth week following confinement

The cantonal Act of 30 August 1921 provides that a mother who nurses her child herself for at least five weeks shall be entitled to an additional nursing bonus of 50 francs and a bonus of 100 francs if she nurses for ten weeks.

St. Gall

Act of 6 July 1914

Insured women are entitled, at confinement, to free medical attendance, including drugs, together with a daily cash benefit of one franc, or altogether to a daily pecuniary benefit of at least four francs, provided they have been members of a fund for at least nine months.

CHAPTER VII

ORGANISATION OF MEDICAL SERVICE

Insurance institutions which provide benefits in kind must organise the payment of these benefits. They must provide medical attendance, arrange for the hospital treatment of sick persons and the care of the infirm and convalescents. But they cannot entrust the administration of these benefits to anyone they please; they must have recourse to medical practitioners and surgeons who are duly qualified to practice under the public health laws. Besides this first rule, which serves as a guarantee for both insured persons and the medical profession, the law lays down that the insurance institution cannot have full freedom to organise the medical service as it pleases. In order that the protection of the sick may be effective, the body which is to be responsible for organising the medical service is defined by law. It may be the institution which pays cash benefits; or, on the contrary, the administration of benefits in kind may be separated from that of cash benefits. The first Section of the present Chapter shows how this question of the bodies responsible for organising the medical service has been settled.

The relations between the medical profession and the insurance system raise complicated and controversial questions in many countries. There is the problem of selecting the doctors who are needed in the system for treating the sick; whether the insurance institution may employ the doctors it prefers or, on the contrary, whether doctors may decide to place themselves at the disposal of insured persons, and if so, whether the number who may do so is limited. In the interests of all the parties concerned, doctors, funds and sick persons, the rights and obligations of insurance doctors must be exactly defined. A medical contract is established at least in its main lines, by way of a national collective agreement and is adjusted to local conditions by local agreements. The method of engaging doctors determines in advance how they are paid. The principal methods of remuneration are a fixed

salary, a fee per insured person or case of sickness, and payment according to attendance. In the second, third and fourth Sections the rules governing the selection of doctors, medical contracts, and the remuneration of doctors are briefly examined, with some references to national laws.

The insurance institutions, in addition to calling in doctors, must provide for the supply of drugs and for hospital treatment. They can make use of existing health institutions, but if these are insufficient for their requirements, or are offered to them on terms which are too onerous compared with their resources, they must themselves provide their own medical equipment. Their powers in this respect are dealt with in the fifth Section.

The last Section of this Chapter draws attention to the growing importance which the insurance institutions in many countries attach to the prevention of disease.

§ 1. — Bodies Responsible for Organising the Medical Service

Under compulsory sickness insurance laws insured persons and sometimes also the members of their families are entitled to medical attendance, which may be given only by persons duly qualified to treat the sick. In order that the protection of insured persons who need medical attendance may be effective, the law defines the bodies responsible for administering the medical service.

The first Compulsory Sickness Insurance Act, the German Act of 1883, entrusted to the sickness funds the duty of providing both for cash benefit and for medical attendance. This twofold function of the sickness funds has been retained in Germany, and also adopted and confirmed by insurance laws in the central European countries, where it is the general rule for the sickness funds to organise at the same time the payment of benefits in kind and in cash. The principle is not affected by the fact that the funds may transfer some of their duties with respect to organising medical attendance to their federations, with a view to the uniform regulation of the payment of benefits in kind. A sick person applies to one and the same institution whatever kind of benefit he claims.

Other systems are to be found, however, in which the insurance institution is not responsible for organising the medical service. The British Act, for instance, does not use approved societies for this purpose, but provides that in each administrative area special

public bodies, the insurance committees, must be set up to administer medical assistance. In spite of the fact that there are these two separate institutions responsible for the payment of benefits there is only one insurance system, of which the approved societies and insurance committees form part, although with different powers.

In those Baltic States which have maintained the principles of organisation contained in the Russian Labour Code of 1912, in Esthonia and Latvia, medical attendance is provided in the first place by employers, who are also responsible for organising the medical service for insured persons. In the absence of an agreement to the contrary the funds have no obligations in this respect, but they have the right to organise their own medical service for the treatment of insured persons and their families.

A third special form of organisation is to be found in Russia where the medical assistance of insured persons and their families is entrusted to the general health authorities. The special rights of insured persons to medical attendance merely take the form of preference over uninsured persons.

The question of the responsibility for organising the medical service hardly arises if the funds are not obliged to provide this assistance in kind, but merely to repay all or part of the medical expenses of insured persons. Except in Norway, the substitution of a cash payment for medical attendance is allowed only as an exception; for instance, if the fund is unable to conclude an agreement on fair terms with a sufficient number of doctors, or because the doctors refuse to abide by the contract.

The above brief survey may be supplemented by an account of certain national laws.

ORGANISATION OF MEDICAL ATTENDANCE BY SICKNESS FUNDS

In *Austria* the new Workers' Insurance Act of 1 April 1927 confirming the present system requires the funds to take the necessary measures for providing suitable medical attendance for insured persons. If a fund entrusts the payment of some or all of its benefits in kind to a federation of funds, it is relieved of its obligation only in so far as this is fulfilled by the federation (section 18, subsection 1).

In *Germany* the obligation of the funds to provide for medical attendance is laid down in section 370 of the Insurance Code, according to which the Superior Insurance Office may not grant a fund the power (subject to revocation) to pay cash benefit instead of providing medical attendance, unless the provision of medical care is seriously imperilled by the fact that the fund cannot conclude a contract on suitable terms with a sufficient number of medical practitioners or the medical practitioners fail to carry out the contract. The Order of 30 October 1923 on the sickness benefit to be granted by funds defines the scope of this exception in greater detail and attaches strict guarantees to its administration.

In *Hungary* the National Workers' Insurance Fund, acting on behalf of the local funds, is responsible for organising the medical service. It draws up the main principles, which the local funds must adapt to particular circumstances.

In *Luxemburg* the Social Insurance Code provides for the establishment of relations between sickness funds and doctors with a view to the treatment of insured persons. Like the German funds, those in Luxemburg may not substitute cash benefit for medical treatment unless such treatment is seriously imperilled by the fact that the fund has been unable to make arrangements on suitable terms with a sufficient number of doctors (section 305, subsection 1).

Similarly, in *Poland* the organisation of the medical service lies with the sickness funds, which must engage qualified medical practitioners for the treatment of sick persons and the members of their families (section 42, subsection 1).

Similar provisions are to be found in the *Czechoslovak* (section 141) and *Serb-Croat-Slovene* (section 150) Acts.

THE BRITISH SYSTEM

The insurance committees are local bodies corporate consisting of 20 to 30 members according to the size of the locality. Three-fifths of the members represent the insured persons, one-fifth are appointed by the county council or the county borough council. The remaining one-fifth consists of three or four members appointed by the local medical committee and the Minister of Health, and one to four members appointed to represent practitioners and women. The committee keeps a list of insured persons, examines all claims for medical benefit and questions arising out of the relations between doctors and insured persons, and enquires into complaints of the medical service. In addition it pays doctors and dispensing chemists out of the moneys it receives from the General Medical Fund. All the material work arising out of the administration of medical benefits is therefore undertaken by the insurance committees (section 12 of the Act).

MEDICAL SERVICE PROVIDED BY THE EMPLOYER

In *Estonia*, where the employer alone is responsible for providing medical attendance, this may be organised by him or by the sickness fund. The 1912 Act provided for the conclusion of agreements under which benefits would be paid by the sickness fund at the expense of the employer. The 1917 Act allows the funds to take the initiative in concluding such agreements, in which case the employer must pay a special contribution of not more than 2 per cent. of his total wage bill. Three of the more important funds have so far made use of this power.

In *Latvia*, too, the cost of medical attendance is met by employers (section 5), but the fund may undertake the provision of medical attendance even without the employer's consent but at his expense. In this case the special contribution to be paid by the employer is fixed by agreement, but is not less than 1 per cent. and not more than 2 per cent. of the wages bill (section 42).

THE RUSSIAN SYSTEM

The treatment of insured persons is entrusted to the health authorities and is subordinate to the Commissariat of Public Health. The insurance authorities must keep in constant touch with the medical authorities, but have no responsibilities in connection with the treatment of insured persons. Questions in which insured persons are involved are examined by the medical sub-committee set up in the Commissariat of Public Health in each of the Federal Republics. The organisation of the medical service is apparently different in the various republics.

§ 2. — Selection of Medical Practitioners

The body organising the medical service must apply to medical practitioners and surgeons to attend insured persons. Without the collaboration of the practitioner the body responsible for providing medical care, whatever its resources, cannot completely carry out its obligations. The doctor who agrees to treat a person liable to insurance becomes of his own free will a protector of the interests of the whole insured group.

It is unusual for the law to allow the parties concerned full freedom to organise the medical service as they choose. In the interests of the insured group, and sometimes also in those of the medical profession, it prescribes a definite method of selecting doctors or allows a choice between various systems. A distinction is usually made between three main systems of medical selection, according to the extent to which doctors are allowed to treat insured persons and sick persons to choose their doctor.

ANY DOCTOR ALLOWED TO TREAT INSURED PERSONS AND FREE CHOICE OF DOCTOR BY THE SICK

Any duly qualified doctor may apply for inclusion in the list of approved practitioners. The mere application gives him the right to treat insured persons, and the body responsible for organising the medical service may not refuse him. This right of the doctor corresponds to the right of the sick person to choose any doctor prepared to treat insured persons. Obviously, the freedom of choice is never so complete as to allow the sick person the right to choose among all the doctors in his neighbourhood, as not all of them are prepared to serve the insurance system: it should, however, enable him to choose among a majority of the doctors in his town or district

APPROVAL OF ANY DOCTOR ACCEPTING THE CONDITIONS OF SERVICE LAID DOWN BY THE FUND, AND LIMITED OR ORGANISED CHOICE OF DOCTOR BY THE SICK

The sickness fund agrees with a medical association on the terms of the contract of engagement. Any doctor, whether belonging to the contracting association or not, who accepts the terms of the

contract may treat insured persons. Sometimes, however, the number of doctors is limited according to the number of insured persons and the members of their families entitled to medical attendance. In this system the sick person has the right to choose his doctor within reasonable geographical limits. The fund may increase the number of doctors to whom the sick person may have recourse, but as a rule it satisfies the law if it allows the choice between not less than two doctors.

SELECTION OF DOCTORS BY THE FUND OR SYSTEM OF PERMANENT MEDICAL OFFICERS

The fund appoints one or more medical practitioners who undertake the treatment of insured persons, and only the doctors chosen by the fund are allowed to treat members. The choice of the insured person is limited to the doctors engaged by contract. Except in urgent cases he must as a rule call in the medical officer for his district.

* * *

A satisfactory settlement of the problem of the selection of doctors is essential to the proper working of the sickness insurance system. The question has raised, and still raises, innumerable controversies between funds and doctors, and there are few countries in which it appears to have been settled finally in the interests of all the parties. It is beyond the scope of the present Report to describe the sometimes very lively discussions to which the question has given rise. All that can be done is to give a brief objective summary of the arguments most frequently put forward on either side.

Doctors claim the natural and inalienable right of each person to choose the doctor he trusts. No doctor can require a sick person to choose him, but he can demand that a third party shall not intervene between him and the patient. The sickness fund acts as an intermediary, and by choosing its own medical practitioners excludes all other doctors, however willing they may be to treat insured persons. This exclusion of a certain proportion of doctors is all the more serious when the proportion of insured persons is high and the private practice of the doctor therefore reduced.

The funds in turn claim their right to conclude contracts with any person they please. No doubt a body responsible for a public

service must not have political or personal preferences, but it is the duty of the fund to see to it that the medical service does not involve a waste of insurance moneys or prove a useless burden on the community. There is, moreover, a difference between insured persons and a private practice. Private patients pay out of their own pocket and can defend themselves against any tendency on the part of the doctor to provide unnecessary attendance. For insured persons, the fund is responsible for providing medical attendance, and there is therefore a risk that the sick person will not on his own account oppose medical attendance out of proportion to the seriousness of his complaint.

It is the business of the legislature to reconcile opposite points of view and interests. This may be done by compulsion, or the doctors and funds may be given more or less freedom.

The systems of medical selection in force in the various countries cannot be rigidly classified. Apart from some States in which the free choice of doctor or the system of a permanent medical officer is established in the law itself, several systems may be found side by side in any one country or district. For this reason the following analysis will be limited to certain standard systems.

In *Austria*, the Act of 1 April 1927 empowers the funds to provide in their rules that the persons entitled to medical attendance shall apply to certain specified doctors, and that the expenses of other doctors will not be met by the fund except in urgent cases. Otherwise patients may choose between the doctors for the area of the fund who are willing to treat insured persons on the conditions agreed with the insurance institution (section 48). In practice, insured persons living in towns must apply to the permanent doctors engaged by their fund, but this system of medical officers is not adopted in all provinces. In the country, insured persons usually apply to doctors who, although not engaged by the fund, have accepted the conditions of payment it has laid down. Free and unlimited choice is allowed only by a small number of funds. In certain insurance institutions intended mainly for industrial salaried employees, the members may themselves decide between the system of medical officers and that of unlimited choice. In the latter case their medical expenses are refunded in accordance with a special schedule. In agricultural sickness insurance the choice of doctor is free and the doctors are paid in accordance with the attendance given.

In *Czechoslovakia*, the insurance institution may decide under section 141 of the Act that persons entitled to medical benefit shall be attended by specified doctors, and that the expense entailed by the calling in of other doctors shall not be repaid except in case of urgent necessity for first aid. Thus, the Act does not impose on the insurance institutions a specified system of medical selection, nor does it guarantee the insured persons the free organised choice of doctor.

In *Estonia*, the law contains no binding provisions. The most important fund, that of Tallinn, has concluded contracts with four medical associations, under which the members of these associations who accept the conditions of the contract are entitled to treat members of the fund. Some doctors have been engaged by the fund under a special contract in order to provide medical attendance in clinics, or in the country where there is no choice of doctor. Sick persons may choose among the doctors belonging to the associations which have accepted the conditions of the contract with the fund.

In *Germany*, the question of the selection of medical practitioners is apparently not yet finally settled. The 1913 Social Insurance Code did not contain final provisions on the point. It was considered inexpedient to impose on the funds the system of unlimited freedom of choice demanded by doctors, for in that case the obligation to enter into agreements would have weighed only on the funds, and doctors could have enforced all their demands. An agreement entered into directly between medical practitioners and funds outside the Act before the Code came into force in December 1913 provided for two systems of medical selection: free choice and organised choice. The funds which adopted the latter system were not obliged to approve more doctors than they chose, but the approval of additional doctors was entrusted to committees on which the doctors and the funds were represented in equal numbers. In spite of the great difficulties of the period of inflation, this agreement remained in force for ten years. On 30 October 1923 when it was due to expire, the Government used its emergency powers to issue an Order on the medical attendance to be provided by sickness funds. This Order, besides protecting the funds against doctors who failed to observe strict economy, abolished the system of organised free choice. No fund is bound to approve additional doctors if the number of insured persons per doctor does not exceed one thousand.

The principles established by the Order of 30 October 1923 are still in force. With certain modifications they were confirmed by the Federal Committee of Doctors and Sickness Funds, a committee set up by the Order in question to settle all questions of principle arising out of the organisation of the medical service for sickness insurance purposes. Sick persons are free to choose from among the doctors already approved, but the approval of additional doctors is subject to the conditions laid down by the decision of the Federal Committee on 14 November 1925, according to which a medical register must be kept in each insurance office. Any doctor who wishes to have the right to treat insured persons must apply for inclusion in the register. The decision on his application is taken by a so-called approval committee, consisting of three representatives each of the funds and doctors. In the district of each insurance office there must be one doctor to 1,350 insured persons, or if the members of insured persons' families are entitled to medical benefit, one doctor to every thousand insured persons. If the number of insured persons per doctor falls below the above figure, but exceeds two-thirds of the figure the fund in question is allowed a waiting period of one year, and if the number is below two-thirds of the figure, the waiting period is extended to two years. In exceptional cases, doctors who have been engaged for not less than two years at the headquarters of the fund may be approved even if the fixed average is not reached. The committee is free to decide on applications for approval, with due reference to the system of medical selection adopted by the fund. In the event of competition, account must be taken of the date on which the candidate obtained a diploma, the date on which he was entered on the medical register, his age, medical training and economic and personal circumstances. If the fund requires the services of a specialist, the committee must approve a suitably qualified practitioner. Any vacancies among the specialists must be filled by specialists in the same field.

In *Great Britain*, any doctor in regular practice is entitled to be entered on the list of insurance doctors for the district or districts in which he practises. He may not be struck off the list except on his own application or after an enquiry showing to the satisfaction of the Minister of Health that he is not qualified to act as an insurance doctor. An insured person may apply to any doctor on the list on proving his right to benefit. Formerly an insured person had to choose his doctor at the beginning of the year and could only change once a year subject to one month's notice. Subsequently the exercise of this right was allowed twice a year, always subject to a special notice. At present the free choice of doctor is subject only to two conditions. The doctor must be willing to treat the sick person, and the number of insured persons on his list must not exceed a certain maximum. The doctor has in turn the right to demand that the name of the insured person shall be struck off his list subject to notice.

There are at present in England, Scotland, and Wales 38,486 doctors on the official medical lists, each of whom is entitled to treat insured persons. Out of

this total 14,645 were acting as insurance doctors in January 1924. In industrial and rural districts, the large majority, and sometimes all, of the doctors are on the medical list. The average number of insured persons per doctor is close on one thousand, the largest number recorded for one doctor being 2,500.

In *Hungary*, the Act of 1907 accepts the system of medical officers, but also that of limited choice (section 133, subsection 2). Since this Act came into force medical practitioners have tried to secure that any doctor who so wishes shall be allowed to treat insured persons. The National Workers' Insurance Fund, on the contrary, has endeavoured to organise the medical service with a comparatively small number of medical officers, responsible to it for the treatment of insured persons.

The medical officers are selected by competitive examination. After a probationary period of one year, their appointments are made permanent, and the contract can then only be cancelled for one of two serious reasons, a disciplinary penalty or professional incompetence for more than one year.

All insured persons must apply to the doctor designated by the fund, and the expenses resulting from calling in other doctors are not met by the fund except in urgent cases. In large funds employing several doctors, the sick person may choose between them. In addition he is allowed a certain freedom in that he can select the clinic to which he must go for treatment.

Since 1919 there has been a steady growth in the number of doctors employed by the funds. The total in 1919 was 1,842, of whom 1,243 were employed by the district funds and 599 by the works funds. It rose by the end of 1924 to 2,487, of whom 1,665 were employed by the district funds and 822 by the works funds. Relatively speaking, however, this increase is not greater than the rise in the number of insured persons and the members of their families entitled to medical benefit during the same period.

In *Poland*, the system of selecting doctors is not strictly defined by the Act, and it has not yet been possible to make the system uniform owing to the wide differences in local conditions. The most general system is that of medical assistance given in the clinics of the funds. Its advantage lies in the facilities it offers for improved supervision of the medical service and for giving sick persons treatment and care in accordance with modern method of diagnosis and therapeutics.

The doctors who have concluded contracts with the fund give consultations in the clinics. Sick persons who have to keep to their bed are visited by the fund doctor at home. The area of the fund is divided into several districts, each covered by local doctors. Their visits are made for purposes of diagnosis, and once the nature of the disease has been established and the first assistance given, the local doctor may call in a specialist or order the sick person to be transferred to a hospital. The total number of doctors employed by the funds at the end of 1923 (excluding former Prussian territory and Upper Silesia) was 1,781, or 29.5 per cent. of the total number of doctors. The Warsaw sickness fund alone employed 170 persons for the treatment of the sick during 1925, including a chief medical officer, two assistant chief officers, one chief dispensing chemist, one hospital director, 117 doctors for internal complaints, 24 neurologists, 32 surgeons, 14 gynaecologists, 24 oculists, and 8 bacteriologists.

In *Roumania*, an insured person must as a rule apply to the doctor designated by the fund, and therefore has no choice. The medical staff employed by the sickness insurance institution was as follows in the years 1923 to 1925.

	1923	1924	1925
Practitioners	263	304	314
Doctors for internal complaints	7	7	9
Doctors for external complaints	39	44	52
Surgeons	143	156	168
Midwives	59	64	67
Visiting nurses	28	28	33

In the *Serb-Croat-Slovene Kingdom*, there are two classes of medical practitioners in the insurance system, medical officers and approved doctors with whom a contract has been concluded.

To each local workers' insurance institution one or more medical officers are attached, one officer being appointed for not less than 800 and not more than 1,400 insured persons. In addition, each local institution has a chief medical officer responsible for the medical service. In districts where the average number of insured persons falls below 800, the local institution concludes a contract with one or more doctors who undertake the treatment of sick insured persons.

The system at present in force does not allow insured persons a choice between several doctors. They must apply to the clinic of the insurance institution, or failing that, consult the medical officer or approved doctor. Insured persons who have to keep to their bed may ask to be visited at home.

§ 3. — Medical Contracts

Medical practitioners are not obliged by law to place themselves at the disposal of the sickness funds for the treatment of insured persons. The organisation of the medical service in a sickness insurance system depends on the conclusion of contracts with doctors.

The terms of the contract between the insurance institution and doctors may be defined in the law itself, in virtue of the law by the executive authorities, for instance, the central authority responsible for the satisfactory working of the system. In this case the doctors and insurance institutions are usually consulted before the general terms of the contract are laid down, but once the contract has been concluded they are bound, and cannot modify it by direct agreement.

The situation is quite different in countries where the law leaves the parties concerned to organise their relations by way of private contract. It will depend on the system of medical selection adopted whether the contracts apply to doctors permanently attached to the insurance institution, or to those who over a shorter or longer period normally render their services to the insurance institution outside its premises.

Doctors attached to the health institution of a sickness fund, such as nursing homes and clinics, are engaged under a contract which defines the nature and duration of their services and fixes their remuneration. Such doctors must as a rule comply with the instructions given by the insurance institution or by the chief medical officer of the institution in all medical matters.

Medical practitioners who are employed in the services of the insurance system are similarly bound by a contract which differs.

however, considerably from that for permanent medical officers. They, too, must place themselves at the permanent disposal of the insurance institution, although the amount of their services need not be strictly defined since it depends very largely on the preferences of the sick. In his work the doctor is bound, with due regard for his professional duties, to comply with the instructions of his employer, the insurance institution. These instructions do not refer to medical treatment properly so called, but to questions of administration, such as the examination of the sick person's right to treatment at the cost of the insurance institution, and the drawing-up of certificates on his loss of working capacity.

As in all other fields of social legislation, it is a matter of dispute whether the conditions of the medical contract are to be settled individually or collectively. When sickness insurance was first introduced this settlement usually took the form of an individual contract between the fund and a limited number of doctors. The medical profession attached little importance to insurance work. The posts of permanent medical officers were offered to the doctors who made the smallest claims. This state of affairs is prejudicial both to the insurance system and to the medical profession. Owing to the economic difficulties of their profession doctors began to consider the idea of collective protection of their material and moral interests. Nowadays, in most countries the contract of any particular doctor with an insurance institution is based on a collective contract between the central bodies representing the medical profession and insurance institutions.

Collective regulation of the relations between doctors and insurance institutions is all the more important when the number of doctors doing insurance work is large. Where the medical service is entrusted to medical officers of the fund, agreement is easily reached. In countries which have, on the contrary, adopted the system of unlimited or organised free choice, the establishment of the guiding principles capable of satisfying both the medical profession and the insurance institutions, whose duty it is to protect the interests of the insured, meets with many difficulties.

A brief account may now be given of the manner in which the relations between doctors and funds are collectively regulated in Germany and Great Britain, the countries in which the number of insured persons and insurance doctors is highest. As regards form there is a capital difference between the two systems, but in practice it is of less importance, and the course of development appears to have been similar: determination of general principles by national

collective contract, adjustment of the national contract to local conditions by local collective agreements, conclusion of individual contracts by acceptance of the collective agreements.

In *Germany*, the Federal Committee of Doctors and Sickness Funds by a decision of 12 May 1924 issued instructions on the general contents of doctors' contracts. These instructions are not binding and do not exclude the principle of freedom of contract: they contain only general principles by means of which uniform and fair regulation of the contractual relations between the parties may be established. In the event of a difference of opinion, the instructions indicate which solution is to be considered as most in conformity with the interests of the two parties.

A doctor's contract may be concluded as an individual or as a collective contract. When the system of medical selection is that of organised free choice, a collective contract is concluded with the association of insurance doctors. Doctors who have contracted with the fund are bound to supply all the medical assistance to which insured persons and the members of their families are entitled under the rules of the fund. They must refuse unnecessary assistance, limit their care to the strict minimum as regards both character and quantity, and avoid any action which may increase the expenses of insurance. In prescribing drugs they must observe the recommendations of the Federal Committee of Doctors and Sickness Funds concerning economy in the prescription of drugs; orders for baths, massage, spectacles and minor appliances must be submitted to the fund before being carried out. Hospital treatment requires the previous consent of the fund. The latter may at any time have the sick person examined by its medical adviser or a medical committee. In the absence of an appeal authority the opinion of the medical adviser or medical committee is final. A doctor's contract is concluded for not less than one year. It is on the basis of these instructions that the relations between doctors and funds must be regulated.

In each social insurance office there is a joint committee of funds and doctors whose duty it is to conclude local contracts in conformity with these instructions. The committees assist the doctors and funds when concluding collective doctors' contracts, and these cannot take effect without the consent of the committee. In the event of disagreement between the funds, the doctors and the committee, the determination of the contents of the collective agreement is left to the decision of the conciliation committees attached to the superior insurance offices and the Federal Insurance Office (section 368, *l-n*). These conciliation committees are bound by the instructions of the Federal Committee of Doctors and Sickness Funds.

The continuity of the doctors' contracts is ensured by a provision under which when a collective contract expires the two parties are bound to observe the conditions in force, until a new contract has been concluded. Thus it appears that sufficient precautions have been taken to prevent differences of opinion between doctors and funds from being left unsettled to the detriment of sick persons.

In *Great Britain*, the principal conditions of the medical service are defined in the law itself and by the Minister of Health, who is responsible for the working of the insurance system. The Minister lays down guiding principles after consulting the Health Insurance Committee set up by the British Medical Association, which is considered to represent the medical profession as a whole. Whereas this Committee may be said to be without official standing, the Act provides for the establishment of local medical committees, giving them certain administrative functions.

The individual contract between a doctor and an insurance committee consists in his acceptance of the terms of service laid down by the Minister and adapted to local conditions by local collective agreements. No exceptions can be allowed to any one doctor. The Minister of Health, as already stated, is responsible for the working of the insurance system. Just as insurance contributions are fixed uniformly, so there must be uniformity in the terms of service of doctors. The Minister need not respect the wishes of individual doctors, but must consult their representatives before defining the general

terms of the contract. The Health Insurance Committee of the British Medical Association consulted by the Minister at present consists of 37 members, of whom 23 are elected directly by the local medical committees. The general terms of the contract lay down, for instance, under what conditions the insured person may choose his doctor, giving him the right to call in any doctor on the list provided that the latter agrees to treat him; the consulting hours for insured persons, the local authorities being empowered to make any changes necessitated by local requirements; the duties of the patient towards the doctor, and the form in which complaints may be made by either side; the conditions under which a doctor may be struck off the list. For local purposes two authorities take part in the conclusion of the medical contract, the local medical committee and the panel committee. Without discussing in detail the limited powers of the local medical committee, it will be sufficient to say with respect to the panel committee that it represents insurance doctors both in the insurance committees, which administer benefits in kind, and in the Health Insurance Committee of the British Medical Association, which is responsible for collective negotiations with the Ministry of Health. The panel committee is consulted by the Insurance Committee before defining, in accordance with the terms of the national contract, the local conditions governing the rights and obligations of insurance doctors.

§ 4. — Remuneration of Medical Practitioners

Remuneration of the doctors employed in the insurance system raises various questions which must be satisfactorily settled if the medical service is to work. Although the question of remuneration is not the sole cause of the differences between the funds and doctors that occur from time to time, it has a serious influence on the attitude of doctors towards the insurance system. The method of remuneration differs with the system of medical selection in force in the country and for the insurance institution. Sometimes several methods of remuneration may be found side by side in any one country, so that the doctor and the fund may choose between them, or even apply two different systems at once.

A distinction may be made according to the principle on which the remuneration is calculated.

FIXED SALARY

The remuneration is fixed at a lump sum for a specified period. It is normally independent of changes in the membership of the fund during the period, not is it affected by the number of cases of sickness or the number of consultations.

This system of remuneration is usually adopted for permanent medical officers, or medical officers responsible for treating the insured either in their own consulting rooms or in the health

institutions run by the insurance funds. Consequently, it is found chiefly in countries which do not allow the sick person free choice of doctor.

Provision is often made for the periodical increases of the salary, annually or biennially, account being taken of length of service; and the doctor, and in some cases his surviving dependants, are entitled after a certain period of service to a pension or dependant's pension.

FEE PER INSURED PERSON

The capitation fee is fixed with reference to the morbidity rate, i.e. the average number of cases of sickness per insured person per annum and the average number of consultations, etc., per case of sickness. The remuneration of the doctor is independent of the number of cases of sickness and of the attendance given, being as many times the fee fixed as he has insured persons in his care.

Under this system the doctor and insurance institution know in advance the amount of the remuneration as it depends on the number of insured persons. As a rule the fee does not cover certain special forms of attendance, such as operations, night visits, drugs administered by the doctor himself.

This system is usual in Great Britain, and is often found in other countries which allow unlimited or organised free choice of doctor, such as Austria, Czechoslovakia, and Germany.

FEE PER CASE OF SICKNESS

Under this system the doctor receives a fixed fee for each case of sickness whatever its duration and gravity. This method of remuneration has the advantage of great simplicity, but is open to the objection that the doctor may be tempted to be too ready to certify as sick the insured persons who consult him. The system is not very widely used.

REMUNERATION ACCORDING TO ATTENDANCE

A unit of medical attendance is chosen, for which a price is fixed, and the different forms of attendance given in the insurance system are referred to this unit according to a scale of coefficients. The

payment of the doctor is then equal to the number of units corresponding to the attendance he has given multiplied by the basic price.

Sometimes instead of a special scale the basis used is the official medical tariff established by the public health authorities, in which case the sickness funds are usually allowed a reduction. Moreover, the total remuneration of the doctor may be subject to certain limitations. For instance, the number of consultations, etc., paid for by the fund is limited per case of sickness, or the number of consultations exceeding a certain average per insured person are not paid for or paid for only in part. There may be an infinite variety in the detail of these restrictions, but whatever their importance the remuneration depends on the amount of attendance given.

This system is particularly suitable in countries where the free choice of doctor is allowed. It is largely employed in Germany and in agricultural insurance in Austria, and is allowed in Czechoslovakia.

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It is hardly within the scope of this Report to examine all the modifications undergone by these various systems of remuneration in practice; methods based on different principles may be combined, maximum and minimum limits may be fixed for the total remuneration of all doctors or of any one doctor. In order to illustrate the differences between the regulations in force, these general observations are supplemented by a brief analysis of certain national systems which are characteristic because they employ only one or else all of the various methods of remuneration.

In *Austria* in industrial centres, allowance being made for certain differences between the provinces, the permanent medical officers of the funds are paid a fixed salary, which may be increased according to length of service, while in the country doctors are paid either per insured person or in accordance with the attendance given. Thus the Vienna district fund pays doctors outside the town an annual fee per insured person of 3 90 to 7 80 schillings, a fee which is increased by half if the families of insured persons are entitled to medical benefit. Similarly, the important Vienna Workers' Mutual Benefit Society pays those doctors who are not engaged at a fixed salary an annual fee per insured person varying between 3 90 and 10 40 schillings. In other provinces, such as Carinthia and Styria, those doctors who are not engaged at a fixed rate are paid according to the attendance given: 1 schilling per consultation, 1 60 schillings per visit. In the agricultural funds the remuneration is usually according to the attendance given, and special travelling allowances are granted.

In *Czechoslovakia* the collective agreements between the six federations of sickness funds and the two national medical associations provide for four different methods of remuneration:

- (a) Payment per case of sickness. Here all the attendance given during the course of one and the same sickness is considered to form a single

unit, whatever the duration of the sickness and whether the attendance is given at home or in the doctor's consulting room.

- (b) Payment per insured person. In this case a fee is fixed per insured person irrespective of the attendance given.
- (c) Payment according to attendance. This is the system under which the various forms of attendance are classified according to a definite scale.
- (d) Payment of an annual fee. This method is of the nature of a fixed salary, which may be increased in accordance with length of service.

Special fees are provided in the case of specialists. In addition doctors are entitled to certain travelling allowances and extra fees for night visits. The system of fixed salaries can be used only for permanent medical officers. Payment by capitation is fairly usual, both for the district medical officers and in the system of organised free choice. Payment according to the attendance given is used, for instance, by the funds which allow sick persons to call in doctors who have not subscribed to the medical contract. In this case the medical expenses of these persons are paid up to the amount fixed in the schedule for the kind of attendance given.

In *Germany* doctors are paid in accordance with the instructions issued by the Federal Committee of Doctors and Sickness Funds on 12 May 1924, either by a fixed fee or according to the attendance given.

The fee may be fixed per case of sickness or per insured person. In the latter event it is based on the average number of cases of sickness per insured person a year, and the average number of consultations, etc., involved in a case of sickness. The fee covers all forms of attendance except hospital treatment, travelling allowances, and special treatment. If the members of insured persons' families are entitled to medical benefit the fee is increased with reference to the average size of the family of insured heads of households.

Remuneration according to the attendance given must be made subject to certain restrictions. Thus the Federal Committee of Doctors and Sickness Funds recommends that the maximum fee to be paid for each case of sickness should be fixed at 7 attendance units. The Committee further suggests that account should be taken of the work done by each doctor and the number of his patients, and that the average number of consultations and visits during the quarter should not exceed the general local average. These restrictions do not apply to special treatment, however, nor to travelling allowances and urgent surgical treatment, or treatment concerning which a previous agreement has been entered into with the fund.

The official Prussian schedule is used as a general basis for remuneration according to the attendance given. This schedule is implicitly recognised as defining the law as between doctors and funds. In 1924 the Prussian Ministry of Social Welfare, which was responsible for drawing up the schedule, had allowed the funds a 20 per cent reduction of its rates in view of their difficult situation. So far as Prussia is concerned this reduction was withdrawn at the beginning of 1927, so that the funds now have to pay medical fees at the full schedule rates.

In *Great Britain* the national regulations allow the insurance committees to choose between various methods of remuneration: either a fee per insured person, or in accordance with the attendance given, or a combined system taking into account both the number of insured persons and certain special forms of attendance given.

At present, payment by capitation has been adopted in all districts but two. The moneys intended for the medical service are paid into a central medical fund, which in turn makes payments to the local funds. The sums to be paid into the central medical fund are obtained by multiplying the number of insured persons by the agreed fee per insured person. At present this fee is 9s. a year. The sums paid into the central fund are allocated to the insurance committees, in proportion to the number of insured persons living in each insurance district, by the Minister of Health assisted by an advisory committee of representatives of the doctors and insurance committees. Doctors are paid quarterly in accordance with the number of insured persons entered on their lists. A certain sum is set aside to cover certain special expenses, such as those relating to the drugs and anaesthetics administered directly by the doctor. A doctor

whose annual number of consultations and visits per insured person is 3.5 a year receives about 2s 6d. per consultation or visit. Attendance usually takes the form of visiting the patient, and sometimes of giving a consultation in the doctor's consulting-room. The time spent on issuing certificates, keeping records and furnishing reports is taken into account.

In the *Serb-Croat-Slovene Kingdom*, medical officers receive a fixed salary determined partly by the number of insured persons for whose treatment they are responsible, and partly by their length of service. They are also entitled to travelling allowances and, with their surviving dependants, to a pension (Regulations for Medical Officers, section 16). The doctors engaged by contract receive a fixed salary based on the average number of insured persons whom they are liable to treat. The annual salary is 800 dinars for 250 insured persons and 2,100 dinars for 800 insured persons. They are entitled to travelling allowances and special fees for important surgical operations (Model Contract for Medical Practitioners, sections 6, 7 and 9).

Doctors who are the victims of an epidemic or an occupational accident have the right to compensation in the form of a lump sum equal to not less than their annual salary. If they die, this sum is payable to the widow and children under age (Model Contract, section 13).

§ 5. — Medical Equipment of Insurance Institutions

In countries where the sickness funds are responsible for medical treatment, it is to their material and moral interest that sick persons should be given as efficient attendance as possible, and that the cost to the insured group should be as low as possible. It may happen that the attendance which a doctor can give in his consulting room or at the sick person's home will not be sufficient for the success of the treatment. Insured persons have as much right as the well-to-do to benefit by medical specialisation and therapeutic progress.

When a sickness fund has been set up, it makes use of the general health institutions of the country: it provides for the admission of sick persons to hospitals and arranges that they obtain the necessary drugs and curative appliances from dispensing chemists or doctors. As public institutions, the sickness funds have been and still are given preferential treatment by law or special agreement, in the form of a reduction in their favour of hospital and pharmaceutical charges.

Nevertheless, the growth of the national medical equipment is not always sufficiently rapid as regards either quantity or quality to meet the needs of the sickness funds, needs which are increased particularly by the extension of medical benefit to insured persons' families. The funds then try themselves to provide the articles and services needed for the proper treatment of the sick. They organise their own medical establishments, and manage them on their own

account, thus making themselves at least partly independent of the medical equipment available to the general public.

The necessary means are provided by law. In most countries with compulsory insurance, the funds or federations of funds are empowered under certain conditions to set up and manage institutions such as sanatoria, clinics, dental institutes, maternity homes and crèches, homes for special treatment, pharmacies, convalescent homes. The funds are thus able to give insured persons and their families the benefit of modern methods of diagnosis and therapeutics.

The sanatoria particularly needed by funds in industrial centres are those intended for the treatment of tubercular persons. In countries which are still without a system of invalidity insurance, the sickness funds are the first to take the initiative in setting up such institutions. The annual reports of the chief funds or federations of funds in Austria, Czechoslovakia, Germany, Hungary, Latvia, Poland, and the Serb-Croat-Slovene Kingdom give an account of the working of the tuberculosis sanatoria.

In certain countries clinics have become the centre of the medical work of the funds, from the point of view both of diagnosis and of therapeutics. They make it possible to concentrate the medical service, placing at its disposal all the necessary appliances. If they are properly equipped they have many advantages that the consulting rooms of doctors, who work without the assistance of a staff, do not possess. In countries which have the system of permanent medical officers attached to the funds, there has been no obstacle to the development of the clinics. These are to be found, for instance, in large numbers in the towns of Austria, Czechoslovakia, Hungary, Latvia, Roumania, and the Serb-Croat-Slovene Kingdom. They are of the greatest importance, in particular for the provision of medical benefit for insured persons' families. Owing to the network of clinics set up in the industrial centres in Congress Poland, family benefits could be made compulsory, and only a few years later over two million members of the families or insured persons could claim such benefits. An illustration of the value of well-organised clinics has recently been given in Germany. The clinics improvised at the end of 1923 in most quarters of Berlin, and retained as permanent institutions, are responsible for the medical attendance of several hundred thousands of persons in the families of the insured. Dental institutes have been set up by the sickness funds in many industrial towns in the central European countries. The work of these institutes has drawn the attention of the working population to the importance of dental treatment.

The collective purchase of these bandages, therapeutic appliances and drugs for which pharmacies have not the monopoly is allowed in most laws, and is undertaken by a very large number of funds. In Austria, Czechoslovakia, Hungary, and Poland, for instance, the funds may set up and run pharmacies for the benefit of their members. In Poland in particular, they have been able to effect considerable economies by thus becoming independent of private trade.

This account may be completed by a few concrete examples, showing the interest taken by insurance institutions in setting up their own medical equipment.

In *Austria*, the Workers' Insurance Act of 1 April 1927 empowers the federations of sickness funds to set up and manage hospitals, convalescent homes and pharmacies, and to organise the collective purchase of therapeutic appliances (section 175, subsection 2). The workers' and employees' sickness insurance funds have at their disposal about 1,800 beds in their sanatoria and convalescent homes. The State Railway Sickness Fund alone owns a tuberculosis sanatorium with over 200 beds and several convalescent homes with 300 beds. Periodically the funds undertake special campaigns to protect children of school age and over in large towns against tuberculosis.

In *Czechoslovakia*, each sickness fund must belong to a federation of funds whose duties include those of setting up and managing hospitals and pharmacies (section 92). In addition, the Central Workers' Insurance Institution may, under section 184 of the Act, use part of its free moneys to carry out general or special measures for preventing premature invalidity among insured persons and their families, and combating national plagues such as tuberculosis, venereal disease, and alcoholism.

For some time the funds and federations of funds have been engaged in setting up health institutions, including clinics, dental institutes, tuberculosis sanatoria and convalescent homes.

In *Germany* the federations of funds may set up and run hospitals and convalescent homes (sections 407 and 414 of the Insurance Code). Moreover, according to the instructions given by the Federal Committee of Doctors and Sickness Funds on 14 November 1925 the funds are empowered to supplement the medical assistance they give and improve the general health of insured persons by opening institutions for diagnosis and consulting-rooms, and making arrangements for mechano-therapeutical treatment.

In the absence of official statistics, an idea of the institutions belonging to the sickness funds may be obtained from the number of hospitals owned by the funds affiliated to the Central Federation of German Sickness Funds (*Hauptverband deutscher Krankenkassen*) at the end of 1925: 3 funds, with about 700,000 members, had their own tuberculosis sanatoria with 370 beds; 79 funds, with an aggregate membership of 3,500,000, had their own convalescent homes with 5,991 beds; 73 funds, with about 2,000,000 members, had dental institutes; 38 funds, baths; 50 funds, special institutes for X-ray treatment.

The Berlin Federation of Sickness Funds has 40 clinics, set up in 1923, to which several hundred doctors are attached. Each clinic is responsible for the treatment of the members of the families of insured persons living in a specified area. It also provides for visits in the homes of sick persons in its area. The doctors are assisted by a nursing staff and can make use of modern equipment.

In *Hungary*, the National Workers' Insurance Fund has five convalescent homes, and it makes arrangements every year that several hundred beds in the sanatoria and spas shall be available for insured persons.

Most of the sickness funds have general clinics and special institutions for dental treatment, nervous diseases, the treatment of internal complaints, surgery, hydro-therapeutics, and respiratory diseases.

In *Poland*, section 44 of the Act empowers the funds to set up for their own use clinics, pharmacies, hospitals sanatoria, convalescent homes, institutions for diagnosis, for special treatment, etc. It is further the special duty of the federations of funds to establish and administer hospitals and pharmacies and to initiate and encourage any measure tending to improve the national health (section 93, subsection 2). Although these provisions did not come into force until 1920, the funds have already set up a considerable body of institutions. At the end of 1924 they had 312 clinics (of which 222 were in former Russian territory), 116 (74) pharmacies, 55 (12) hospitals, 1 (1) maternity home, 7 (5) sanatoria, 18 (3) rest homes, 39 (6) Roentgen institutes, 66 (20) ultra-violet ray apparatus, 23 (9) analytical laboratories, 1 (1) biological laboratory, 5 (5) pharmaceutical laboratories.

In the *Serb-Croat-Slovene Kingdom* the Central Workers' Insurance Institution has five convalescent homes and sanatoria with 550 beds, three of which, with 450 beds, are for the treatment of tuberculosis.

§ 6. — Prevention of Disease

During the last few years the sickness insurance authorities have become increasingly aware of the importance of preventive medicine. Even admitting that the most highly perfected methods of social hygiene can never altogether destroy the tendency of the human body to disease, yet most sicknesses may be prevented by vigilant preventive action. Losses in productive capacity may be obviated or delayed. Thus resources which are exhausted by avoidable disorders may be set free, and the life of insured persons and the community as a whole made easier and more healthy.

There are many directions in which the sickness funds can take preventive action. The protection given to maternity under the sickness insurance system, the benefits in cash and in kind granted to mothers, whether they themselves are insured or are the wives of insured persons, is a form of prevention which benefits not only the mother, but the child, the new generation. Any measures to promote the nursing of infants by their own mothers, or their supervision in crèches, or to give the mother advice on the proper care of children under school age, must increase the chances that the future generation will grow up free from physical defects. The extension of medical benefit to the families of the insured is also an important form of preventive work. The fact that the members of working-class families have access to medical advice means that the greater part of the working population is subject to medical supervision. They acquire the habit of consulting doctors, and begin to realise the importance of obtaining medical advice in the early stages of a complaint.

The insurance authorities may go even further in their preventive action. National plagues, such as tuberculosis, rheumatism and

venereal disease, ravage the under-nourished, badly-housed sections of the population who are ignorant of the rules of hygiene. In the populous quarters of industrial centres the breeding of tuberculosis in particular never ceases. Curative treatment of this disease is ineffective from the social point of view, which demands the protection of other persons rather than the cure of the patient. The separation of the sick person from his family is essential, and medical supervision and extra feeding are necessary to protect the children of tubercular persons. A complete network of institutions, services and activities is indispensable if the fight against tuberculosis is to be successful. The insurance authorities may participate or even take the initiative in this work.

There is a risk that the physical development of children of school age and over may be hampered by the inadequacies of their homes or by the fatigue which an undeveloped body may suffer from apprenticeship to an industry or trade. The sickness insurance system may protect its future members by supervising and organising country holidays for young persons with a tendency to disease.

The insurance authorities also try to persuade the workers to practice rules of health. They have to fight against ignorance and indifference, and to make clear to all the individual and collective value of health.

Preventive action must not be too rigid. It should be adapted to local needs and be directed to those points where the health of the population is most vulnerable. This is the reason why the law does not require the funds to pursue a definite course, but allows free play to their initiative and experience. The prevention of disease has not yet been included among the aims of all insurance laws, and even when it is so included it is not always widely applied. Yet the number of insurance laws which authorise preventive measures is already considerable and appears to be increasing steadily.

The provisions which authorise the adoption of preventive measures take various forms. Individual prevention, that is to say, measures for insured persons who, without being sick, show a tendency to disease, may be allowed in the form of optional benefits. General prevention in favour of the whole wage-earning population may be promoted by using insurance funds to improve the health of the population as a whole. The insurance authorities may construct or assist in the construction of sanatoria and rest homes, organise social health exhibitions, issue periodicals for health propaganda, provide for the needs of holiday camps, etc.

The references given below to certain more advanced national laws may serve as an indication of the manner in which sickness funds may take preventive action.

In *Austria*, the Workers' Insurance Act of 1 April 1927 empowers the funds and their federations to use their resources for taking measures to improve the health conditions of the insured population (section 58, subsection 4). In this respect the Act merely confirms the established practice of the sickness funds, especially in the fight against tuberculosis. Since 1918 the funds have doubled the number of beds at their disposal in tuberculosis sanatoria. They pay special attention to protecting children against tuberculosis, assisting mothers, and helping apprentices in industry and commerce. A joint institution of the chief sickness funds arranges seaside and mountain holidays for thousands of working-class children.

In *Czechoslovakia*, preventive action is taken by the Central Social Insurance Institution. According to section 154 of the Act, the Central Institution may introduce, either on its official initiative or at the request of the person concerned or the competent sickness insurance institution, curative treatment for the purpose of deferring or postponing invalidity which may result from the sickness of an insured person, his wife (husband) or widow (widower). Moreover, part of the moneys of the Central Institution may be used to carry out or assist in general or special measures for combating national plagues (tuberculosis, nervous disorders, venereal disease, alcoholism, cancer, etc.) or for raising the general level of health among insured persons and their families (section 184). These provisions seem to offer a suitable foundation for systematic preventive action.

In *Germany*, the sickness funds were authorised by the 1911 Social Insurance Code to use their resources for the general purpose of preventing disease. It was understood that such preventive measures should apply to all the members of the fund and should not aim at the individual protection of any one insured person. The Act of 19 July 1923 extended these powers in two directions: (a) nowadays the resources of the funds may be used for both general and special prevention of disease, (b) the funds have power to take measures to prevent disease among certain insured persons.

The large territorial funds and their federations make very wide use of the power to take preventive action. They use all methods of prevention, mostly in co-operation with other bodies set up for the same purpose. Instruction in the ruins of health, by way of lectures, the press and the cinematograph, is systematically developed. The funds also provide for ante-natal consultations, by means of which pregnant mothers may be supervised and given medical treatment with a view to normal confinements. In other fields of social health, such as the protection of children, the fight against tuberculosis and venereal disease, the funds act in co-operation with the invalidity institutions.

The conviction that the prevention of disease calls for concentration of all the action taken to this end has become general. The Act of 28 July 1925 on the protection of health by social insurance bears witness to this fact. It empowers the Government, after consulting the funds and medical practitioners, to draw up instructions on the medical treatment to be given in the social insurance system and the general measures to be adopted by the insurance institutions to prevent premature invalidity and improve the health of the insured population. These instructions are also to organise the co-operation of the insurance institutions with public and private organisations for the promotion of social health and assistance. The object in view is to concentrate in each district the activities of all the institutions interested in the improvement of the health of the population. The sickness funds, the invalidity insurance institutions, the communal authorities and the social welfare organisations will no longer be able to act on their own initiative, but the measures to be taken will be decided on as part of general scheme by the territorial bodies they have formed. The work which any one doctor acting alone is unable to carry out will thus be entrusted to a body which has the necessary resources for systematic action.

In *Poland*, the resources of the sickness funds may be used under section

88 of the Act for "general purposes of medical assistance and the prevention of disease". The federations of funds in particular are responsible, among other things, for the "initiation and encouragement of all measures tending to improve the health of the country" (section 93, subsection 2). In spite of the fact that the funds are of such recent date, they are greatly interested in the prevention of disease, and take action on a large scale by granting medical assistance to the members of insured persons' families.

In *Russia* the efforts of preventive medicine are directed towards developing sanatoria and curative establishments. In 1924 10,000,000 roubles were spent for this purpose; in 1925, 20,000,000; in 1926, 25,000,000; and in 1927 an expenditure of 35,000,000 was budgeted for. Some of the beds are maintained by the central insurance administration and the others by the insurance funds.

International Tabular Summaries: Benefits

TABLE I — CONDITIONS FOR AWARD OF STATUTORY SICKNESS BENEFIT

Country	Qualifying period of insurance	Day of incapacity as from which benefit begins to be paid
Austria	—	if sickness lasts more than 3 days, first.
Bulgaria	8 weeks	first
Chile	7 months	fifth, if sickness lasts more than one week, first.
Czechoslovakia	—	fourth, if sickness lasts more than 11 days, third.
Esthonia	—	fourth
France (Alsace-Lorraine)	—	fourth
Germany	—	fourth
Great Britain and Northern Ireland	26 weeks	fourth
Irish Free State	26 weeks	fourth
Hungary	—	third
Italy (New Provinces) . .	—	fifth
Japan	—	fourth
Latvia	—	fourth
Lithuania	Fixed by rules of each fund.	fourth
Luxemburg	8 days	third
Norway	—	fourth
Poland	four weeks, applies only to temporary and home workers.	third
Portugal	6 months	first
Roumania (Former Kingdom)	6 weeks	if sickness lasts more than 3 days, first.
Russia	—	first
Serb-Croat-Slovene Kingdom	—	if sickness lasts more than 3 days, first.
Switzerland:		
Appenzell, Inner Rhodes	14 days ¹	second
Outer Rhodes	—	third
St. Gall	14 days ¹	third

¹ Unless the insured person was already member of another recognised sickness fund.

International Tabular Summaries: Benefits

TABLE II — AMOUNT AND DURATION OF SICKNESS BENEFIT

Country	Rate of statutory benefit payable		Duration of statutory benefit	Additional cash benefits	
	to insured person incapable of work	to dependants of hospital inmate		Prolongation of duration of statutory benefit up to	Increase rate of statutory benefit
Austria	66 ⅔-80 % of basic wage	50 % of statutory benefit	52 weeks (26 weeks for persons insured for less than 30 weeks)	1 ½ years	by 20-33 ⅓ % of basic wage
Bulgaria	42-30 levas a day plus 1 leva for each child	8-12 levas a day	9 months	—	—
Chile	12 ½-100 % of wage according to duration of illness and family responsibilities	—	unlimited	—	—
Czechoslovakia	66 ⅔ % of basic wage	50 % of statutory benefit	1 year	—	by 10-30 % of basic wage according to duration of illness and family responsibilities
Estonia	50-66 ⅔ % of wage	—	26 weeks (30 weeks in the course of any year)	—	—
France (Alsace-Lorraine)	50 % of basic wage	50 % of statutory benefit	26 weeks	52 weeks	by not more than 25 % of basic wage
Germany	50 % of basic wage	50 % of statutory benefit	26 weeks	52 weeks	by not more than 25 % of basic wage
Great Britain and Northern Ireland	15s weekly for men 12s for women	Whole or part of statutory benefit at discretion of fund	26 weeks	—	according to financial situation of fund
Irish Free State					
Italy (New Provinces)	50 % of basic wage	50 % of statutory benefit	26 weeks	—	—

Japan	60 % of basic wage	20-60 % of basic wage according to number of dependants	180 days	—	—
Latvia	66 ⅔-100 % of basic wage according to family responsibilities	Whole or part of statutory benefit according to rules of fund	26 weeks (30 weeks in the course of any year)	—	—
Lithuania	50-100 % of wage according to family responsibilities	—	26 weeks	—	—
Luxembourg	50 % of basic wage	50 % of statutory benefit	26 weeks	52 weeks	by not more than 25 % of basic wage
Norway	60 % of basic wage	20-50 % of basic wage according to number of dependants	26 weeks (39 weeks in cases of tuberculosis or cancer)	—	—
Poland	60 % of basic wage	50 % of statutory benefit	26 weeks (39 weeks if fund is established more than 3 years)	52 weeks	by not more than 25 % of basic wage
Portugal	0.06-0.30 escudos a day according to wage class and duration of illness	—	365 days	—	—
Roumania: Former Kingdom	35-50 % of basic wage according to family responsibilities	10-25 % of basic wage	16 weeks	—	according to financial situation of fund
Ardeal and Bukovina	60 % of basic wage	50 % of statutory benefit	26 weeks	period fixed by rules of fund (Bukovina)	—
Russia	100 % of wage	whole statutory benefit	unlimited	—	—
Serb-Croat-Slovene Kingdom	60 % of basic wage	50 % of statutory benefit	26 weeks	52 weeks	by not more than 33 ⅓ % of basic wage
Switzerland: Appenzell Inner Rhodes Appenzell Outer Rhodes St Gall	3 francs a day 4 franc a day 4 francs a day	— — —	180 days } in the course of 180 days } 180 days } 360 days	— — —	— — —

International Tabular Summaries: Benefits

TABLE III — FUNERAL BENEFIT

Country	Amount of funeral benefit for insured person		Character and maximum amount of funeral benefit for dependants
	statutory minimum	maximum which rules of funds may fix	
Austria	30 times the basic daily wage	45 (times the basic daily wage (max 150 schil)	optional; fixed by rules of fund
Bulgaria	50 times the basic daily wage	—	—
Chile	300 pesos	—	—
Czechoslovakia	30 times the basic daily wage (min. 150 cr)	45 times the basic daily wage	compulsory, 60-250 crowns according to age of deceased
Estonia	20-30 times the basic daily wage	—	optional; fixed by rules of fund
France (Alsace-Lorraine) . .	20 times the basic daily wage	40 times the basic daily wage	optional; for wife $\frac{1}{2}$, and for child $\frac{1}{2}$ of funeral benefit for insured
Germany	20 times the basic daily wage	40 times the basic daily wage	optional; for wife $\frac{1}{4}$, and for child $\frac{1}{2}$, of funeral benefit for insured
Great Britain and Northern Ireland, Irish Free State	—	—	—
Hungary	30 times the basic daily wage	40 times the basic daily wage	optional, up to 20 times the basic daily wage
Italy (New Provinces) . . .	20 times the basic daily wage (min. 20 yen)	—	—
Japan	25 times the basic daily wage	—	—
Latvia	20-30 times the basic daily wage	—	—
Lithuania	$\frac{1}{4}$ of annual earnings	—	optional; fixed by rules of fund
Luxembourg	75 crowns (min. 200 fl.)	—	compulsory, fixed by rules of fund
Norway	21 times the basic daily wage	—	optional, for wife $\frac{1}{2}$, and for child, $\frac{1}{2}$ of funeral benefit for insured
Poland	4,250-3,000 lei according to wage class	—	compulsory, 10 $\frac{1}{2}$ times the basic daily wage
Portugal	30 times the basic daily wage	—	—
Roumania (Former Kingdom)	210-1,000 lei according to wage class	—	—
Ardeal	21-45 roubles according to locality	—	—
Bukovina	30 times the basic daily wage	—	—
Russia	—	—	—
Serb-Croat-Slovene Kingdom	—	—	—
Switzerland	—	45 times the basic daily wage	compulsory; for person over age 10, the local monthly wage, and for other persons, half optional; 50-200 dinars according to age

International Tabular Summaries: Benefits

TABLE IV — MEDICAL BENEFIT FOR DEPENDANTS

Country	Beneficiaries	Nature of benefit	Maximum duration of benefit
<i>1. Compulsory Benefit</i>			
Austria ¹ . .	Members of family dependent on insured.	Same as for insured except sickness benefit.	26 weeks.
Czechoslovakia	Spouse and children under 17, older children, grandchildren, ascendants, brothers and sisters, who have lived with insured for 6 months before illness	Same as for insured except sickness benefit.	1 year.
Germany . . (miners)	Spouse and children.	Medical and hospital treatment, 80-70 % of cost of drugs	26 weeks.
Hungary . .	Members of family in insured's household.	Medical treatment and drugs.	1 year.
Lithuania	Members of family.	Medical treatment.	13 weeks.
Norway . . .	Spouse and children dependent on insured.	Medical and dental treatment.	26 weeks.
Poland . . .	Spouse, ascendants, descendants, brothers and sisters, wards, illegitimate children dependent on insured.	Same as for insured except sickness benefit.	13 weeks.
Portugal . .	Wife and children under 16; other members of family incapable of work.	Medical treatment and drugs.	Unlimited.
Roumania (Former Kingdom, Ardeal, Bukovina)	Wife and minor children.	Medical treatment at home or dispensary; drugs at reduced prices.	16-26 weeks.
Serb-Croat-Slovene Kingdom	Wife by marriage or cohabitation, children, grandchildren, parents, grandparents, brothers and sisters.	Medical and other necessary treatment, drugs and appliances	26 weeks.
<i>2. Optional Benefit</i>			
Austria . . .	Members of family dependent on insured.	Same as for insured except sickness benefit.	52 weeks.
Bulgaria . .	Members of family.	Medical treatment and drugs.	9 months.
France (Alsace-Lorraine)	Members of family.	Medical treatment and drugs.	26 weeks.
Germany . .	Members of family	Medical and hospital treatment and drugs	26 weeks.
Great Britain ² and Northern Ireland ² , Irish Free State ²	Persons dependent on labour of insured.	Medical treatment	Not prescribed.
Latvia . . .	Members of family.	Medical treatment.	26 weeks.
Luxemburg .	Members of family.	Medical treatment and drugs.	26 weeks.
Russia . . .	Members of family	Same as for insured except cash benefit	Unlimited

¹ New law, not yet in force as regards manual workers.² The benefit is never in fact granted.

International Tabular Summaries: Benefits

TABLE V — STATISTICS OF EXPENDITURE ON CASH BENEFITS AND BENEFITS IN KIND

Country	Year	Average value per insured of all benefits	Proportion of total expenditure on benefits represented by benefits in		Remarks
			cash %	kind %	
Austria	1919	97.4 paper crs	64.7	35.3	Without mining funds.
	1924	50.9 schillings	52.4	47.6	
Bulgaria	1919	14.8 levas	—	—	
	1925	104.6 „	22.03	77.97	
Chile	1925-1926	10.02 pesos	25.2	74.8	1 July 1925 to 30 June 1926.
Czechoslovakia: Bohemia, Moravia and Silesia . . .	1919	59.13 crowns	61.25	38.75	Without mining funds in Bohemia, Moravia and Silesia.
	1924	266.55 „	58.13	41.57	
Slovakia and Sub-Carpathian Russia	1921	189.04 „	54.20	45.80	
	1924	200.81 „	57.15	42.35	
Estonia	1923	1 800.74 Esth. mk	58.2	41.8	
	1924	2,037.38 „	51.2	48.8	
France (Alsace-Lorraine)	1919	77.7 francs	56.90	43.20	
	1923	155.0 „	49.03	50.97	
Germany	1913	29.22 marks	46.4	53.6	Without mining funds which expended 72.92 marks, 56.7 % being for benefits in kind.
	1924	45.60 „	41.9	58.1	
Great Britain	1914	£1.06	55.4	44.6	
	1925	£1.75	62.3	37.7	
Northern Ireland .	1923	£1.17	93.75	6.25	Including disablement benefit.
	1924	£1.37	92.8	7.2	
Hungary	1913	23.19 crowns	48.2	51.8	
	1924	324,690 paper cr.	51.87	48.3	
Irish Free State . . .	1924	£1	—	—	Including disablement benefit.
	1925	£1.08	93.8	6.2	
Luxemburg	1913	40.88 francs	47.38	52.62	
	1923	119.76 „	38.13	61.82	
Norway	1917	24.81 crowns	45.0	55.0	
	1924	56.30 „	41.9	58.1	
Poland	1924	39.63 zloty	32.22	67.78	Including funds in Polish Upper Silesia.
Roumania: Former Kingdom	1913	5.18 lei	54.2	45.7	
	1925	138.43 „	35.5	64.5	
Ardeal	1919	20.38 „	45.3	54.7	
	1925	297.56 „	44.4	55.6	
Bukovina	1922	151.5 „	38.0	62.0	
	1924	253.0 „	29.2	70.8	
Russia	1925-1926	44.55 roubles	50.7	49.3	
Serb-Croat-Slovene Kingdom	1923	217.60 dinars	51.50	48.50	
	1925	282.26 „	43.40	56.60	

PART III

FINANCIAL RESOURCES AND THEIR MANAGEMENT

PART III

FINANCIAL RESOURCES AND THEIR MANAGEMENT

CHAPTER I

SOURCES OF FUNDS

§ 1. — Raising of Funds

Compulsory sickness insurance, whose aim is not only "compensation", but also "repair" in as favourable conditions as possible, and indeed "prevention", undertakes functions which far exceed individual interests and which in certain respects make of it a public service. This being so, two factors have to be considered, between which a preliminary adjustment must always be made. On the one hand, there are the expenses entailed by the working of insurance, and, on the other, the charge on the national dividend in order to cover these expenses. *A priori*, persons who share in the national dividend are in a similar position with respect to any obligation to contribute to the insurance, including, of course, the persons exposed to the risk themselves. All solutions of the problem adopted deserve examination, from those which place the burden on the community by means of taxation to those which restrict the obligation to contribute to definite classes.

It would, however, be inconvenient to examine the problem throughout on such general lines, and in order to limit its scope it is as well to turn from theory to facts. It will then be found

that the methods of raising funds in force in various countries involve separately or jointly the insured persons, employers, and the public authorities (the State, commune or some intermediary administrative institution), and these are the three types of "persons" to which the present examination will be limited.

The considerations which may justify having recourse to or excluding any one of these three are of great variety. Those of a more theoretical nature are practically all based on the idea that participation in the burden depends either on a *responsibility* in the widest sense for the occurrence of the event insured against, or on the *advantages* received in the shape of benefit and, in general, from the working of insurance. Side by side with these there are practical reasons, often more convincing, which have obviously had a preponderating influence on the legislation of the different countries. It is proposed to review here some of the arguments more frequently adduced, the reader being referred for a fuller treatment of the subject to that contained in the report on "General Problems of Social Insurance" ¹.

§ 2. — Insured Persons, Employers, and Public Authorities in the Matter of the Raising of Funds

INSURED PERSONS

Setting aside the cases of sickness wilfully incurred, which nearly always deprive the insured persons of their rights, individual responsibility is regarded as the residuum which cannot be assigned to social or occupational causes. But as there is obviously a certain degree of arbitrariness in the definition of the actual causes, especially for those of the first kind, the residuum will itself vary with the definition adopted. At all events, it does not seem possible to eliminate it altogether and the argument of responsibility leads to the admission of the principle of the participation of the insured person.

The force of the argument drawn from the advantages obtained is evident, for after all the insured person is the principal and direct beneficiary under insurance.

¹ INTERNATIONAL LABOUR OFFICE: *General Problems of Social Insurance*. Studies and Reports, Series M (Social Insurance), No. 1. Geneva, 1925.

There are other reasons, this time of a practical nature, in favour of workers' contributions. Three of these may be cited.

In the first place the workers' contribution definitely creates in the eyes both of the public and of the insured person himself a well-marked distinction between insurance and relief, and makes clear to all his right to benefit.

Further, not only does it give him the right to share in the financial management of insurance — a point which is not necessarily self-evident, for no reason can be offered why he should not manage funds to which he has not contributed — but in addition it gives him adequate reasons for making use of this right. Insurance becomes his personal affair; and his care for the patrimony which he has helped to build up cannot but have a happy effect on the working of the institution.

Finally, the regularly repeated efforts of individual and collective foresight represented by the payment of the contributions make it possible to link up compulsory social insurance effectively with the various existing mutual aid organisations, whose activities have been particularly marked in the field of sickness insurance. Provided there is a certain flexibility in its administrative organisation, the compulsory system may thus benefit by the favourable impression made on the public mind by mutual aid institutions, and by the forces of good-will and propaganda already attaching to them. It no longer appears as a creation of the powers that be, unexpectedly fallen from the skies and regarded with some suspicion because of its origin and because it is always surprising to receive something for nothing. It has precedents which are well known, and where payments are made each for all, all and each know where they stand.

Moreover, in whatever way workers' participation is justified, it must always be subordinate to the examination of a preliminary question, relating to the theory of wages. If it is proved that wages normally contain a surplus intended for provident purposes, the sickness insurance fund has obviously the right to claim its share, but in no other case. In the following Chapter it will be shown that in Europe during the period 1919-1923 the cost of sickness insurance (including maternity benefit and funeral benefit) — inequalities due to the varying amount of benefit being smoothed out — approximated to about 4 per cent. of the average wage. When it is remembered that the risk of sickness is not the only or the most serious of the contingencies which the workers have to meet, and that very little is needed to upset the equilibrium of a

budget which in any case has little elasticity, it will be realised how carefully the workers' contributions must be adjusted. At all events and whatever decision may be taken for more highly-paid workers, it seems expedient to make special provision for insured persons with low wages, for independent workers who cannot count on the support of an employer's contribution, and perhaps also for those voluntarily insured persons who leave the compulsory system for other reasons than an improvement in their income, or join without being in a better economic situation than the average insured person.

EMPLOYERS

To begin with, occupational diseases in the strict sense of the word should be set aside, that is to say, diseases specifically caused during employment by certain technical processes or the handling of certain substances. In the various countries compensation for such diseases is already to some extent, and will doubtless become increasingly so, the subject of special measures connected with the compensation for industrial accidents¹.

Side by side with diseases of this kind there are many which are remotely or incidentally connected with engagement in an occupation. This applies, for instance, to tuberculosis contracted in industrial occupations which produce dust that is not particularly noxious for chemical or physical reasons; it applies also to various diseases due to the overworking of certain muscles or certain organs, or to painful or forced attitudes, or, finally, to the general fatigue caused by excessively prolonged or intense work. To this may be added the chances of infection created by the herding together of workers in workshops or other workplaces

If it is further established that the sickness rate varies definitely with the occupation, other conditions being assumed equal, the influence of the "industrial" factor will be evident. Now, this fact appears from various statistics which will be summarised in the following Chapter², to which the reader is referred. A few figures will be quoted here.

According to the statistics published by the Leipzig Fund, covering 28 years of working, the annual frequency of sickness for clerks in the age-group 35 to 44 years was 21.6 per one hundred

¹ INTERNATIONAL LABOUR OFFICE: *Compensation for Occupational Diseases*. Studies and Reports. Series M (Social Insurance), No. 30 Geneva, 1925.

² See "Morbidity by Occupations", p 443

insured, and the average number of days of sickness per insured person per year was 5.8. The corresponding figures for workers in the same age-group were respectively 40.5 and 8.9 in the textile industry, 44.8 and 9.8 in the transport industry, 49.6 and 11.1 in the metal industry, 51.7 and 11.7 in the building industry, and 58.2 and 17.5 in stone-working.

In examining these figures it must, of course, not be forgotten that industrial accidents are included in the above averages, so far as the first 13 weeks of incapacity are concerned. Nevertheless, it remains true that variations of such a size reveal the importance of occupation as a factor of morbidity.

The extension of the principle of "occupational risk" is, moreover, not the only theoretical justification for the employer's contribution to sickness insurance. It is also argued that it is the duty of the undertaking to include in the costs of production the cost of maintaining and replacing the "human capital" it uses. Such maintenance remains due during periods of involuntary loss of working capacity. In this sense, the employer's contribution is regarded as an integral part of wages; this part, however, is not paid to the worker individually together with his wages, but is incorporated in a sum which, although calculated at so much per worker, is collective and is retained by the insurance institution for use when needed. Thus in every respect the employer's contribution is seen to be the outcome, as is in fact generally admitted by those concerned, of the position he holds in the national economy.

As regards the advantages derived by the undertakings from the working of insurance, these are generally classified under one of the following heads: harmony and solidarity between the two principal factors of production; increased output of labour owing to the conditions of safety and health in which the workers are employed. This leaves out of account the fact that the compulsory employers' contribution eliminates competition between those undertakings which have taken the initiative in setting up sickness-relief funds, either entirely at their own cost or with the assistance of a moderate contribution from their workers, and those which have failed to guarantee their workers against this risk.

PUBLIC AUTHORITIES

Evidently the State shares in the responsibility for the majority of preventible sicknesses in so far as it may fail to watch over the

maintenance of public health and effectively to supervise general health conditions, domestic and industrial activity, and education. It may even be added that cases of physiological distress due to inadequate wages may be directly laid to the door of the modern State if it has failed to introduce minimum wage legislation.

The advantages derived by the community from a body of rational measures for treating and preventing sickness are fairly obvious. On the one hand, the health conditions of all social classes change, whether for better or worse, at the same time; on the other, when a person with small means has to meet the risks of sickness out of his own resources alone, sickness becomes one of the most frequent causes of pauperism. It is also one of the most frequent causes of the impossibility of escape from pauperism. As the 1909 Report of the British Royal Commission on the Poor Laws states: "It is probably little, if any, exaggeration to say that, to the extent to which we can eliminate or diminish sickness among the poor, we shall eliminate or diminish one-half the existing amount of pauperism."

In spite of this it may be estimated that the financial intervention of the State in compulsory sickness insurance may perhaps be less necessary than in voluntary social insurance against the same risk. In the latter case the mutual aid organisations formed by the persons concerned themselves cannot as a rule exist without outside assistance — in particular, without the support of public subsidies. But in compulsory insurance, the State, which is free to arrange the method of raising the funds in the best interests of all, is itself required to define and distribute the charge to be imposed on the national income. For this purpose it may determine the initial incidence of this tax, as it may justly be called, without necessarily adopting the circuitous method of including in the national budget all or part of the costs of insurance.

NON-CONTRIBUTORY INSURANCE

This is the term given to systems of social insurance under which no payment from those covered is demanded. An account has already been given of the reasons put forward in justification of the worker's contribution. The advocates of non-contributory insurance oppose these on grounds based usually on the precariousness and inadequacy of wages, or on the consequences logically implicit in the conception of insurance as a public service. Nor is

the "State service" formula the only one adduced, for certain systems would make the employer alone responsible for insurance, an extension being given, in the direction indicated above, to the idea of occupational risk or of costs of production. It may be as well to observe that when the example of compensation for industrial accidents is cited, it is often forgotten that most laws leave the injured person to bear part of the economic loss he incurs.

§ 5. — Methods of Sharing by Insured Persons, Employers, and Public Authorities

INSURED PERSONS

For the insured persons it is scarcely possible to consider other participation than that in the total contribution or insurance premium. Nevertheless, there are certain sickness insurance systems in which the insured persons themselves pay a certain proportion of the cost of benefit (control ticket¹; share in cost of drugs). But such measures are not usually intended to relieve the liabilities of the funds and improve their financial position. They are intended to make the insured person careful in exercising his right to benefit.

EMPLOYERS

For the employer, too, the usual system is that of participation in the total contribution. Sometimes, however, if the law empowers employers to create funds to act as insurance organs for their undertakings, they are frequently under an obligation to undertake all or part of the costs of administration. Moreover, measures are as a rule prescribed as regards the additional risks for particularly unhealthy industries, or as regards penalties for employers whose work is defectively organised from the point of view of health.

PUBLIC AUTHORITIES

It is in the method of participation of the public authorities that the greatest diversity is to be found. In the first place, this may

¹ *Ticket modérateur.*

take the form of a share in the total contribution as in the case of the insured and the employers. This method may be applied in respect of all insured persons indiscriminately, or in particular of insured persons with low wages or those without pay (apprentices) or finally those who cannot claim an employer's contribution. A very similar method of participation is that consisting in a subsidy calculated at a fixed rate per person insured, or in a total subsidy estimated in proportion to the total contributions received.

Other methods of subsidy are completely independent of contributions. From the financial standpoint they constitute not so much additional assistance as an alleviation of liabilities¹. An instance of this kind is afforded when the State undertakes to support annually a proportion of administrative expenses. The subsidy becomes even more specifically a contribution towards insurance expenses if the State or the communes undertake to pay part of the benefits. The usual tendency is to reserve this form of responsibility to benefits of particular social importance, such as maternity benefit.

In addition to these forms of direct participation reference may be made to the indirect, and by no means negligible — at present less so than ever — assistance sometimes given by the State in granting various privileges to the sickness funds such as free postage or exemption from taxation. In this connection mention may also be made of various provisions requiring the commune to "lend" the sickness funds their staff or premises, to supply them with records, etc.²

These considerations may be closed by three observations, which, without diminishing the importance of the problem of the distribution of costs, make it possible to give it its proper place in the body of questions relating to sickness insurance.

The first is that whatever theory may be adopted, it obviously cannot be used to deduce exact rules for determining by means of a numerical coefficient the fair share to be apportioned to insured persons, employers and public authorities respectively.

The second is that in view of the advantages to be derived by individuals and the community from the working of insurance,

¹ This applies, of course to the final results. From the book-keeping point of view they figure on the credit side.

² For the purposes of this study the burden borne by the authorities is not taken to include any share they may take in the working of supervisory or special judiciary bodies. Similarly, cases in which the authorities or other persons guarantee the payment of the benefits are left out of account (see Chapter II, § 7, "Guarantees", p. 540).

the distribution of the costs remains a secondary matter, provided that they are not excessive, that there is neither waste nor prodigality, and that account is taken of the ability to pay of the persons called on for the purpose. It may be added that in periods of economic prosperity the burden will hardly be felt, but that in periods of depression everyone will always consider that he has to bear more than his fair share.

The third is that after all the law can merely determine the initial incidence of the burden. The ultimate incidence, which in fact determines the share borne by each, depends on a number of economic and social factors which are both complex and unstable. All that can be said of them here is that as a rule they tend to impose on consumers a fraction of the cost of insurance roughly proportional to the amount of wages incorporated in the finished product.

§ 4. — Raising of Funds under the Various Laws

Among the laws studied in this Report there is only one in which the insurance funds are derived from the contributions of the insured persons alone. In none are the public authorities, or the employers and public authorities together, the sole contributors. Finally, under one law the funds are derived from the insured persons and a group of persons ranging considerably beyond that of employers. Under these conditions the laws may be classified according to the origin of the funds in six groups;

- (1) insurance cost borne by insured persons alone (1 law);
- (2) insurance cost borne by employers alone (1 law);
- (3) insurance shared by insured persons and public authorities (4 laws);
- (4) insurance cost shared by insured persons and employers (11 laws);
- (5) insurance cost shared by insured persons, employers and public authorities (14 laws);
- (6) insurance cost shared by insured persons and a group not consisting exclusively of employers (1 law).

The manner in which the funds are raised for these various groups will be described below. For purposes of convenience and with a view to avoiding repetition, no attempt has been made to adhere closely to a strict order. Thus the study of the measures

taken for certain special cases (insured persons without pay, extra risk premiums, etc.) has been referred to a separate Section¹. This same Section also contains the provisions on insured persons with low wages, except for the third group, for which it was considered more reasonable to place them in the general study of the laws in this group. Finally, owing to the manner in which the material was presented, it was decided to place the statistics for the second group immediately after the description of the laws, while for the other groups they have been compiled in tables placed at the end of this Chapter because they cannot be correctly interpreted until the legislation as a whole has been studied.

FIRST GROUP: INSURANCE COST BORNE BY INSURED PERSONS ALONE

One law: *Roumania* (former Kingdom and Bessarabia).

The insurance funds are derived solely from the contributions of the insured; neither employers nor the State make any contribution.

SECOND GROUP: INSURANCE COST BORNE BY EMPLOYERS ALONE

One law: *Russia*.

It should first of all be remembered that the Soviet social insurance system is at present unitary and covers all the risks: sickness, death, accidents, unemployment. It is therefore impossible to separate the funds relating to sickness insurance. The Act of 31 October 1918 established only one All-Russian Relief Fund. After the new policy was introduced, special funds were set up for the various risks, namely: Fund A, temporary incapacity (and complementary forms of insurance); Fund B, invalidity; Fund C, unemployment; in addition a separate fund for medical attendance (Fund D) was formed. In 1924 this system was abolished. The three funds for invalidity, temporary incapacity, and unemployment, were combined to form a so-called "Working Fund", only the Medical Attendance Fund being kept separate.

According to the 1922 Labour Code, the resources of social insurance are derived from contributions paid exclusively by the undertakings, establishments, and institutions employing wage-

¹ § 5, p. 426.

earners (section 178). If any credits are allocated to social insurance in the State budget, they are paid by the State in its capacity as employer. It should be pointed out, however, that the initial assets, such as buildings, furniture, etc., and hospitals, were placed by the State at the disposal of the social insurance services.

Free insurance for the worker is thus a characteristic of the Soviet system. Under the Czarist regime, according to the Act of 1912, social insurance contributions were paid by the employers and the insured, the employer's share ranging from 0.66 per cent. to 1.33 per cent. of wages, and the worker's share from 1 per cent. to 2 per cent. In 1917 the Provisional Government decided that the payment of insurance contributions should be divided equally between employer and worker. After the October revolution all insurance contributions became payable by employers. When the scope of insurance was extended by the Act of 31 October 1918, contributions were paid by employers and by the independent workers allowed to insure under the system.

The financial statistics of social insurance date from 1922. In that year, however, revenue and expenditure were still calculated in the paper money of the day (Soviet roubles), which was depreciating with increasing rapidity. It is therefore impossible to take the figures of 1922 into account. All that can be stated is that the payments were extremely irregular.

For 1923 no total figures are available but only the receipts per 100 persons insured, shown for the different funds in existence at that time. The figures for the insurance fund for temporary incapacity are given separately ¹. These figures are given in real roubles ².

RECEIPTS PER 100 INSURED, 1923

All insurance	1,760.60 real roubles
Insurance against temporary incapacity	620.27 " "
Insurance for medical attendance	379.13 " "

For 1924 the figures available are given in chervonetz roubles. They give the receipts for insurance in general excluding medical attendance per 100 persons.

¹ *Social Insurance in the Soviet Union in 1923*, p. 31.

² The real rouble is a fictitious monetary unit, calculated from the index number of prices, and having the pre-war purchasing power of the gold rouble.

TOTAL INSURANCE RECEIPTS PER 100 INSURED

1924. January	404.65 chervonetz roubles		
„ February	415.27	„	„
„ March	364.91	„	„
„ April	387.88	„	„
„ May	506.55	„	„
„ June	468.93	„	„

If the receipts of invalidity insurance are taken to be 67 per cent. of the total insurance receipts (the present proportion for expenditure)¹, it will be seen that the receipts for such insurance less medical attendance were 1,740 chervonetz roubles per 100 persons insured for half the year, or 3,480 chervonetz roubles a year.

From October 1924 to March 1925 the distribution per 100 insured was as follows:

Local Funds (all insurance) . . .	2,288 chervonetz roubles		
Local Medical Attendance Funds . .	967	„	„
Reserve Fund	248	„	„
Total . . .		3,503 chervonetz roubles	

The following comparison may thus be made if the real rouble of 1923 is taken as equivalent to 2 chervonetz roubles.

ANNUAL RECEIPTS PER 100 INSURED FOR ALL INSURANCE LESS MEDICAL ATTENDANCE

1923	1,381 real roubles		
1924	1,741	„	„
1925	2,288	„	„

This indicates a considerable rise in the receipts per person insured, a fact which may, however, be due solely to the rise in wages, the monthly average of which, in real roubles, varied as follows in industry:

1922-1923	15.88 ²		
1923-1924	21.45 ³		
1924-1925	25.20 ⁴		

The proportion of the sums received to those due also rose.

¹ *Insurance in 1923-1924* p 21

² *Insurance in 1923-1924*, p 21.

³ *Statistical Year-Book*, Vol. II, p 489.

⁴ *Labour Statistics, 1925*, No X-XI.

During 1923, the collection of contributions still met with considerable difficulties, but there began to be an improvement in the situation. On the one hand the Commissariat for Labour imposed penalties on negligent employers, while, on the other, it made allowance for economic difficulties by reducing the often rather excessive rate of insurance contribution (12 April 1923). These two measures helped to regularise the collection of contributions. If the total sum collected for January 1923 is equated to 100, the index will be found to have risen by the end of 1923 to 218. For Fund A (sickness) the rise was even as much as from 100 to 248, and for Fund D (medical attendance) from 100 to 253 ¹.

For 1923 the following table is available ²:

	Due	Collected	Per cent
January	410.40	404.65	98.6
February	478.95	415.27	86.7
March	553.14	364.95	66.0
April	543.83	387.88	71.3
May	555.85	506.55	91.1
June	533.61	468.93	87.9

During 1924-1925 there was a considerable improvement in the collection of contributions ³. The percentages received of the sums due varied as follows:

1924: July	87.7	1925: January . . .	97.2
„ August	82.8	„ February	97.6
„ September . . .	98.8	„ March	100.4
„ October	88.2		
„ November . . .	88.9		
„ December . . .	95.3		

The improvement in 1925 was largely due to the payment of arrears. At present (July 1926) about 95 per cent. of the contributions appear to be paid.

THIRD GROUP: INSURANCE COST SHARED BY INSURED PERSONS AND PUBLIC AUTHORITIES

Four laws: This system is to be found in Switzerland, in the Cantons which have introduced compulsory sickness insurance, namely, *Appenzell* (Outer Rhodes and Inner Rhodes), *Basle Town*, and *St. Gall*.

¹ *Social Insurance in 1923.*

² *Social Insurance in 1923-1924.*

³ *Social Insurance in 1924-1925.*

Under these various laws the costs of insurance are met by contributions from the insured (except necessitous persons), cantonal or communal subsidies, and federal subsidies; no contribution is demanded of the employer.

In the Canton of Appenzell (Outer Rhodes) the communes are responsible for the contributions of necessitous persons who are compulsorily insured in the public fund. The consequent expenditure is refunded to the communes by the Canton up to half the amount after deducting the subsidy received by the communes from the Federal Government, or up to 30 per cent. in respect of the contributions (for women and children) paid by the commune, provided that its participation is not in the nature of relief. Further, all the cantonal public funds are bound to reinsure with a reinsurance fund, and the State pays annually a sum to the latter fund which must not be less than three times the total sum paid by all the re-insured funds.

In the Canton of Appenzell (Inner Rhodes) the only provision, in addition to that for the federal subsidy, is for a communal subsidy. The unpaid contributions of necessitous persons are met by the commune of residence, which is entitled to have them refunded by the insured person or the commune of origin.

The Canton of Basle Town pays all or part of the contribution up to a certain annual income limit, as shown in the table below:

Group of insured persons	Annual income	Percentage of contribution	
		Met by the State	Met by the insured
I	(a) Single persons, up to 1,800 francs	100	—
	(b) Families up to 2,500 francs. 500 francs per child	100	—
II	(a) Single persons, from 1,801 to 2,200 francs	66 $\frac{2}{3}$	33 $\frac{1}{3}$
	(b) Families, from 2,501 to 3,500 francs 500 francs per child	66 $\frac{2}{3}$	33 $\frac{1}{3}$
III	(a) Single persons, from 2,201 to 3,000 francs	33 $\frac{1}{3}$	66 $\frac{2}{3}$
	(b) Families, from 3,501 to 4,500 francs 500 francs per child	33 $\frac{1}{3}$	66 $\frac{2}{3}$
IV	(a) Single persons, 3,001 francs and over	—	100
	(b) Families, 4,501 francs and over: 500 francs per child	—	100

In the Canton of St. Gall the State grants subsidies to the communal hospitals in respect of the insurance of women and

children, and undertakes part of the expenditure on the insurance of necessitous persons.

Federal subsidies are granted under the same conditions to all sickness insurance funds working in Switzerland which have obtained official recognition. They are governed by the Federal Act of 13 June 1911 on sickness and accident insurance, being fixed as follows:

Subsidy Per Person Insured

- (a) 3.50 francs for each child insured up to and including the year in which it reaches the age of 14 years;
- (b) 3.50 francs for insured men,
- (c) 4 francs for insured women, if the fund insures all its members without distinction for medical attendance and drugs, or for a daily unemployment benefit of not less than 1 franc;
- (d) 5 francs if the fund insured both medical attendance and drugs and a daily unemployment benefit of not less than 1 franc.

These subsidies are increased by 50 centimes for members for whom the fund insures sickness benefit for not less than 360 days in a period of 540 consecutive days.

General Subsidy Corresponding to a Proportion of Contributions

The Federal Government refunds to the Cantons and communes one-third of the expenditure they incur in covering the contributions of necessitous insured persons.

Sharing in Cost of Benefits

The Federal Government pays a subsidy of 20 francs in respect of each case of maternity benefit. In certain cases this subsidy is raised to 40 francs for insured persons who are entitled to a nursing allowance.

FOURTH GROUP: INSURANCE COST SHARED BY INSURED PERSONS
AND EMPLOYERS

11 laws: *Austria, Czechoslovakia, Esthonia, France (Alsace-Lorraine), Greece, Hungary, Italy (new provinces), Luxemburg, Roumania (Ardeal, Bukovina), Serb-Croat-Slovene Kingdom.*

Under the above laws one of two systems is used for dividing the total contribution between employer and worker:

(a) The total contribution is divided equally between the employer and the insured in Czechoslovakia, Esthonia, Greece, Hungary, Roumania (Ardeal), and the Serb-Croat-Slovene Kingdom.

(b) The insured person pays two-thirds and the employer one-third of the contribution in Austria, France (Alsace-Lorraine), Italy (new provinces), Luxemburg, and Roumania (Bukovina).

It should be mentioned, however, that in Hungary the State defrays the administrative expenses of the National Workers' Insurance Fund, which are included in the State budget and are not met out of the receipts from contributions.

FIFTH GROUP: INSURANCE COST SHARED BY INSURED PERSONS, EMPLOYERS, AND PUBLIC AUTHORITIES

14 laws: *Belgium* (seamen), *Bulgaria*, *Chile*, *France* (miners and seamen), *Germany*, *Great Britain*, *Irish Free State*, *Japan*, *Latvia*, *Lithuania*, *Northern Ireland*, *Norway*, *Poland*.

The apportionment of the contribution among insured persons, employers and public authorities will be discussed first, then that among insured persons and employers alone for the countries in which the authorities do not share directly in the contribution; and finally, the participation of the authorities otherwise than in the contribution.

Contribution Shared by Insured Persons, Employers, and Public Authorities

This system is in force in Bulgaria, Chile, Latvia, Lithuania, and Norway.

The contribution is divided in three equal parts (one-third paid by the State, one third by the employer and one-third by the insured) in Bulgaria¹ and Lithuania². The division of the contribution is the same in Latvia, but the employer also bears the expense of medical aid.

¹ Under the Bulgarian Act the State contributes by paying a sum equal to half the total obtained from the other contributors to the funds. As the payments of employers and workers are equal, the system is in fact that of "tripartite" insurance.

² New law (September 1926) The Act of 9 December 1925 made no provision for State participation, but made the employer responsible for two-thirds of the contribution.

In Chile the insured person pays two-sixths, the employer three-sixths, and the State one-sixth of the contribution.

In Norway the apportionment differs for district funds and recognised funds as will appear from the table below:

	Insured person	Share of contribution met by		
		Employer	State	Commune
District Funds . .	6/10	1/10	2/10	1/10
Recognised Funds	2/6	1/6	2/6	1/6

Further, for the recognised funds, the shares of the employer, the State, and the commune may not exceed 4, 2, and 2 crowns respectively per insured person.

Contribution Shared by Insured Persons and Employers

Except in certain particular cases discussed below, the financial intervention of the State does not take the form of a share in the contribution in Belgium (seamen), France (miners, seamen), Germany, Great Britain, the Irish Free State, Northern Ireland, Japan, and Poland.

The insurance contribution properly so called is thus met solely by the employer and the insured person, in the following proportions:

	Share of contribution met by	
	Insured person	Employer
Belgium (seamen) ¹	1/2 or 3/8	1/2 or 5/8
France { miners ²	1/2	1/2
{ seamen ²	2/9 or 3/17	7/9 or 14/17
Germany	2/3	1/3
Japan	1/2	1/2
Latvia	1/2	1/2
Poland	2/5	3/5

It should be observed that in Germany the charge borne by employers is not always limited to their share in contributions. In the first place, the greater part of the administrative expenses of the establishment funds is met by them. Secondly, the rules of the guild funds may provide for the division of the contribution into half, but in point of fact very little use is made of this right. Finally, in a general way the rules of a sickness fund which covers a large area may, in agreement with the managing committee and after consultation with the doctors of the fund, require the employers

¹ According to the grade of seamen (corresponding in a general way to the distinction between officers and crew).

² Until the Act of 4 December 1923 came into force the employer paid one-third and the insured two-thirds of the total contribution.

to pay, in respect of the workers they employ, the travelling expenses of the doctors and the sick persons.

The cases of Great Britain, the Irish Free State and Northern Ireland must be considered separately.

In Great Britain, the contribution is independent of wages, except for persons 18 years of age or more paid at certain low rates. It is fixed at a flat rate, which is different for men and women, and has been amended on several occasions as will appear from the table below:

		Total weekly contribution d	Insured person's contribution d	Employer's contribution d
1914 Act	{ Men . . .	7	4	3
	{ Women . .	6	3	3
1920 Act	{ Men . . .	10	5	5
	{ Women . .	9	4	5
1925 Act	{ Men . . .	9	4½	4½
	{ Women . .	8½	4	4½

It follows that at present the contribution is divided between insured and employer in the following proportions:

	Share of contribution met by	
	Insured person	Employer
Men	1/2	1/2
Women	8/17 (47 per cent)	9/17 (53 per cent)

Thus, although the relative share varies for men and women, the sum paid by the employer remains unaltered.

In the Irish Free State the total contribution is 8d. for men and 7d. for women, in both cases 4d. being paid by the employer, so that the apportionment between the insured person and the employer is equal for men, while for women the insured person pays three-sevenths (43 per cent.)

Sickness insurance in Northern Ireland at present involves a total contribution of 7d. for men and 6½d. for women, the employer paying 3½d. for men and women. Thus, there is a variation according to sex in the employer's share, which is for men one-half and seven-thirteenths (54 per cent.) for women.

In Great Britain, Northern Ireland and the Irish Free State a system of special contributions is in force for the crews in the foreign-going merchant service¹. In Great Britain the total contribution is reduced to 6½d. for men and 6d. for women per

¹ A similar system is in force for members of the Forces, but it was considered that the study of this special case lay outside the scope of the present Report.

week, of which the employer's share is 2d. in each case. In the Irish Free State the total contribution is 7d. for men and 6d. for women, of which 3d. (three-sevenths or 43 per cent., and a half respectively) is paid by the employer. In Northern Ireland the total contribution is 6d. for men and 5½d. for women, the employer paying 2½d. in both cases, or respectively five-twelfths or 42 per cent., and five-elevenths or 45 per cent.

In brief, it will be seen that in the British and related laws the contribution paid by the employer is a fixed sum, although his share in the total contribution is relatively higher (with one exception) for women than for men.

Financial Participation of Public Authorities Otherwise than in Contributions

The fact that the public authorities undertake to pay part of the contributions as a rule excludes any other form of participation. This is reasonable if the total contribution represents the actual value of the insurance premium. The Chilean Act, however, contains provisions of a special nature in that it draws on groups of persons who are neither insured, nor employers, nor the general taxable community, as a subsidiary source of funds. For the funds for sickness insurance are derived also from:

- (1) A tax of 1 per cent. on the amount of all payments made by the State or the communes (except for the foreign debt service, charitable allowances or free educational allowances, purchases from abroad, salaries and pensions).
- (2) An additional licence duty imposed on foreign insurance companies, amounting to 2 per cent. of their gross receipts (reduced to 1 per cent. for life insurance companies).

Among the countries in which the State subsidy does not normally take the form of a share in the contribution, reference may be made to France, where seamen's insurance used to be subject to similar provisions. The annual revenue of the Seamen's Provident Fund included the sum derived from a deduction of 0.5 per cent. on all Admiralty purchases. This deduction was abolished in the 1926 budget.

There remain for consideration the methods of participation by the authorities in those insurance systems under which the contribution properly so called is met solely by the insured and the employers. There are two general types of subsidy: a share in the cost of benefits, or a general subsidy.

Share in Cost of Benefits

In Germany the State pays half the maternity benefit granted to uninsured women who are members of the family of insured persons.

In Great Britain one-seventh of the benefits granted to insured men and one-fifth of those to insured women are paid by the State. In the Irish Free State the State pays for two-ninths of the benefits. In Northern Ireland the proportion is the same as for Great Britain. It may be added that the part played by this subsidy in the working of the institution in these three countries cannot be made clear without a discussion of the technical bases of the financial organisation of the insurance funds ¹.

In Japan the State pays 10 per cent. of the benefits up to a maximum of 2 yen per insured person.

The Polish State bears the whole cost of medical treatment and the supply of drugs incurred on behalf of unemployed persons (who have ceased paying contributions) and the members of their family. It also pays half the maternity benefit and nursing allowances granted by the funds.

General Subsidies

These subsidies are often a relic of the period when sickness insurance was organised on the subsidised voluntary system.

Thus in France the miners' relief societies, which were originally treated in the same way as mutual aid societies, may obtain from the State allowances, varying in amount, derived from the subsidy intended for societies of this kind.

Under the earlier legislation of the Grand Duchy of Luxemburg (before the Act of 17 December 1925 came into force), according to the Act of 8 March 1919 the State met half the administrative expenses of the regional funds. It also granted subsidies to the mutual aid societies which were recognised as organs for compulsory insurance.

For the insurance of seamen in France the Act of 1905 provided for a State subsidy out of deductions from the grants to the mercantile marine. The Act of 19 April 1906 converted this direct deduction into a budget credit equal to a certain proportion of the estimates for shipping grants (two-thirds of 9 per cent. under the

¹ See p. 502.

Act of 1926 but

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distribution of the total burden among the persons contributing to the insurance can be determined only from the financial results over a certain number of years.

In principle, the rates charged are as follows:

For the "actually" insured, according to class¹, a monthly contribution of 0.50, 0.40, or 0.30 escudo. For the "born" insured, according to income a monthly contribution of 0.10, 0.20, 0.30 or 0.50 escudo.

Further, mutual aid societies may receive pecuniary assistance from the Compulsory Social Insurance Institution if this is necessary on the occasion of an epidemic.

§ 5. — Raising of Funds in Special Cases

INSURED PERSONS WITH LOW WAGES

It will be shown in the following Chapter that, except in the Swiss Cantons in which sickness insurance is compulsory, Great Britain, the Irish Free State, Northern Ireland and Portugal, and except for certain special schemes, sickness contributions are fixed in proportion to wages. It is thus assumed, although the point is not indisputable, that the principle of proportionality provides a sufficient and as fair a means as may be desired of alleviating the contribution of insured persons with low wages, and that there is no need to adopt a special system of apportioning the total contributions due in their respect among the insured persons, their employers, and, if necessary, the public authorities.

Esthonia, Japan, Latvia, Norway, and the Serb-Croat-Slovene Kingdom, however, are an exception to this rule. In Esthonia and Latvia the contribution for persons whose money wage is less than two-thirds of the average wage of an unskilled worker must be paid by the employer. In Japan, for persons who earn less than 55 sen a day the contribution is payable by the employer alone. A similar provision is in force in the Serb-Croat-Slovene Kingdom for persons whose remuneration in cash is less than the basic wage in the lowest wage class (or 2 dinars a day). In Norway no contribution is paid by persons in the lowest wage class.

¹ See p. 479.

If the contribution is not in proportion to wages, it is generally felt that the insured persons whose wages fall below a certain limit should be assisted in paying their share of the contribution. The measures adopted for this purpose, or for the insurance of necessitous persons, in the Cantons of Appenzell, Basle Town and St. Gall have already been described.

In Great Britain, the Act classifies as insured persons with low wages those who are 18 or more years of age and who earn less than 4s. a day and whose remuneration does not include board and lodging. The total contribution is fixed as for other insured persons, but it is paid by the employer alone if the wages are less than 3s. If the wages are over 3s. but less than 4s., the normal rate of 4½d. for men and 4d. for women is changed to 3½d. and 3d. respectively, the employer's share being in both cases 5½d. (i.e. eleven-eighteenths or 61 per cent. for men and eleven-seventeenths or 65 per cent. for women, of the total contribution).

In the Irish Free State and Northern Ireland the definition of insured persons with low wages, and their division into two groups are the same as in Great Britain. For persons in the lower group the employer pays the whole contribution. For those in the higher group the total contribution remains the same as for all other insured persons, but is divided as follows:

	Total contribution	Insured person's contribution	Employer's contribution		
			Amount	Proportion of total	Percentage of total
	d	d.	d.		
Irish Free State:					
Men	8	3	5	5/8	62
Women	7	2	5	5/7	71
Northern Ireland:					
Men	7	2 ½	4 ½	9/14	64
Women	6 ½	2	4 ½	9/13	69

INSURED PERSONS NOT PAID IN CASH; APPRENTICES

Under certain laws, if the insured persons are not paid in cash, the employer alone is responsible for paying the whole contribution in their respect. This is so in Austria, Czechoslovakia, Lithuania, Norway (except for agricultural labourers), Poland, and the Serb-Croat-Slovene Kingdom.

Under other laws, according to which the insured and the employer share in the contribution, wages in kind are estimated according to certain rules, and the worker is liable to his employer for the fraction of the contribution due from him under the law.

For unpaid apprentices the rule is that the employer alone pays the contribution. This remains the rule, even if they are paid (provided that their remuneration is less than the normal wage of a worker of the same category), in Bulgaria (below a daily pay of 5 levas), Chile, Czechoslovakia, Hungary, and the Serb-Croat-Slovene Kingdom.

VOLUNTARILY INSURED PERSONS

There appears to be no exception to the rule that a voluntarily insured person pays a contribution equal to the shares of the compulsorily insured person and his employer. This does not prevent the State from sharing in the contribution of voluntarily insured persons if it contributes at all. Thus in *Norway* persons who insure voluntarily in the district funds pay seven-tenths of the contribution, the remaining three-tenths being divided between the State and the commune as for persons insured compulsorily. In *Chile* persons voluntarily insured pay half the contribution, the other half being met by the State.

EXTRA RISK PREMIUMS

It will be shown in the following Chapter that as a rule the sickness insurance contribution is not a "risk premium". Nevertheless, when for certain classes of insured persons the cost of the risk substantially exceeds the average cost, it may be advisable to adopt special measures. An increase in the cost of the risk giving rise to an "extra premium" may arise if (a) the frequency of the risk is increased owing to the nature of the occupation or the inherent conditions of the undertaking; (b) the value of the risk is increased by an increase in benefits for certain classes of insured persons.

In either case, the law does not always empower the insurance funds to adapt the premium to the value of the risk¹.

¹ See "Influence of the Gravity of the Risk" p. 450

If it allows an extra premium to be charged under the rules of the fund, the cost may be met either by the employer or by the insured person alone, or be divided between them in the ordinary way. A few examples may be given here.

In Germany the rules may fix a schedule of rates of contribution according to the industry or occupation of the insured persons. In this case the increased contribution is divided in the standard ratio of 2 to 1. But the funds may also adopt another method if the increase in the risk is attributable to the nature of the industry, for the rules may increase the employer's contribution for certain industries in which the risk of sickness is considerably higher. Similar provisions are in force in Luxemburg, Lithuania and the Serb-Croat-Slovene Kingdom. In Japan, if the contribution is increased for "dangerous" undertakings, the Minister of the Interior may raise the employer's share to not more than two-thirds.

Other provisions take rather the form of a penalty imposed on employers who do not comply with certain health and safety regulations in the equipment of their undertaking. Thus in Austria the contribution of persons employed in an undertaking which does not satisfy the health regulations may be increased by up to 50 per cent. of the normal contribution, and this supplement is met by the employer alone. There are similar provisions in Czechoslovakia and Hungary.

Sometimes the funds are empowered by the law to adopt rules increasing the contributions for certain insured persons who may obtain benefit in excess of the legal minimum either for themselves or for the members of their family. If the funds take advantage of this authorisation, the additional contribution payable for such insured persons must be met by them, unless other arrangements are agreed with their employers. This is the case in Austria, Chile, France (Alsace-Lorraine), Germany, and Luxemburg.

Certain other provisions of detail which may also result in modifying the normal apportionment of insurance costs are left out of account, as the effects are hardly perceptible.

* * *

The information given above on the source of insurance funds is summarised in the table on pages 430-431.

Country	Share of contribution borne by		Financial	
	Insured person	Employer	Share of contribution	
Austria	2/3	1/3	0	
Belgium (seamen)	1/2 or 5/8	1/2 or 3/8	0	
Bulgaria	1/3	1/3	1/3	
Chile	2/6	3/6	1/6	
Czechoslovakia	1/2	1/2	0	
Estonia	1/2	1/2	0	
France (Alsace-Lorraine)	2/3	1/3	0	
France (miners)	1/2	1/2	0	
France (seamen)	2/9 or 3/17	7/9 or 14/17	0	
Germany	2/3	1/3	0	
Great Britain { Men	1/2	1/2	0	
{ Women	8/17	9/17		
Greece	1/2	1/2	0	
Hungary	1/2	1/2	0	
Irish Free State { Men	1/2	1/2	0	
{ Women	3/7	4/7		
Italy (new provinces)	2/3	1/3	0	
Japan	1/2	1/2	0	
Latvia	1/3	1/3	1/3	
Lithuania	1/3	1/3	1/3	
Luxemburg	2/3	1/3	0	
Northern { Men	1/2	1/2	0	
{ Women	6/13	7/13		
Ireland	6/10	1/10		
Norway (District Funds)			State	2/10
			Commune	1/10
Poland	2/5	3/5	0	
Portugal	Variable share	Variable share	0	
Roumania (former Kingdom and Bessarabia)	1	0	0	
Ardeal	1/2	1/2	0	
Bukovina	2/3	1/3	0	
Russia	0	1	0	
Serb-Croat-Slovene Kingdom	1/2	1/2	0	
Switzerland				
Appenzell (Outer Rh.)	1	0	For poor Commune 1/2, Canton 1/2 less Federal subsidy.	
	Poor: 0			
Appenzell (Inner Rh.)	1	0	For poor Commune, 1 less Federal subsidy	
	Poor 0			
Basle Town	0-1 according to income	0	Canton 1-0 according to income less Federal subsidy.	
St. Gall	1	0	Commune and Canton, for poor: variable shares less Federal subsidy.	
	Poor. variable share.			

participation of public authorities		
Subsidy per insured person	General subsidy	Share of cost of benefits
0	0	0
0	Variable subsidies	0
0	0	0
0	0	0
0	0	0
0	0	0
0	0	0
0	Grant from fund for subsidising mutual aid societies	0
0	0	0
0	0	1/2 maternity benefits for uninsured wives of insured persons.
0	Cost of central administration	1/7 of benefits (men)
0	0	1/5 of benefits (women)
0	Cost of administration of National Workers' Insurance Fund	0
2/9 of 2d. } per person	0	2/9
2/9 of 2d. } per week	0	0
0	0	10 per cent of benefits maximum of 2 yen per person
0	0	0
0	0	0
0	0	0
1/7 of 2d. } per person	0	1/7 of benefits (men)
1/5 of 2d. } per week	0	1/5 of benefits (women)
0	0	0
0	0	Cost of assisting unemployed and dependants: 1/2 maternity benefit, 1/2 nursing benefit.
0	Subsidies of Institute of Soc Ins against epidemics	0
0	0	0
0	0	0
0	0	0
0	0	0
0	0	0
Children 3.50 fr. a year	Refund to Cantons and Communes of 1/3 of cost of insuring poor	20 francs per confinement <i>plus</i> 20 francs if person is entitled to nursing benefit.
Men 3.50 fr. or 5 frs a year		
0		
Women 4 or 5 fr. a year		
Subsidies increased by 0.50 fr. in certain cases		

is not specified, the State is intended.

CHAPTER II

SYSTEM OF BALANCING REVENUE AND EXPENDITURE

§ 1. — Financial Autonomy

The previous Chapter has shown which persons or groups of persons are drawn on in a compulsory sickness insurance system for the necessary funds. The next problem is to describe the methods generally used for determining what the amount of such funds should be, and estimating the total periodical contribution in respect of each insured person¹.

Obviously a study of this kind must be based on a postulated financial autonomy of the insurance institution. In point of fact, this preliminary condition is satisfied in all the countries covered by this Report. The term should not be taken to mean complete freedom in financial management; it merely signifies that from the financial point of view the insurance institution is a separate entity. The autonomy may be enjoyed by the whole body of institutions operating within the territory of the country, their financial results being combined in a single account, or by each of the bodies created to administer the law, each being bound to balance its own accounts.

For the moment there is no need to examine the very important consequences, from the point of view of the working of the insurance, of the manner in which the bodies enjoying financial autonomy are defined in space and time. All that need be assumed is that these bodies exist, that they are strictly defined, and that each comprises a sufficient number of members for the so-called law of large numbers to apply, account being taken of the average frequency of the risk. Each of these bodies, when regarded as a financial entity, thus forms what is called an insurance "fund".

It is true that in some countries the financially autonomous bodies are responsible for managing other branches of insurance as well as sickness insurance, and collect composite contributions

¹ For convenience "the contribution in respect of each insured person" will be referred to briefly as "the insurance contribution".

without indicating what part is intended to cover the risk of sickness. Moreover, in almost every country sickness insurance is supplemented by a form of insurance against death (funeral benefit) and by maternity insurance (allowances during pregnancy, confinement, nursing). For the present theoretical study, however, only sickness insurance properly so called will be considered.

§ 2. — Financial Systems

The classic division of financial insurance systems into those of *distribution of costs* and those of *capitalisation* are no doubt familiar to the reader. Perhaps the simplest way of obtaining a sufficiently exact idea of the distinction is to treat insurance as a current account opened by the insurance fund for the insured group. This account differs from ordinary current accounts in one essential respect: the deposits and payments are not made at the will of the depositor. The deposits are quite fixed, both as to amount and as to date of payment, by the conditions of insurance. The payments are made as and when the events insured against occur and in accordance with the conditions laid down in the contracts or rules. In addition, provision is made for an annual inclusive allowance to cover administrative expenses.

In a system of simple distribution of costs the account is opened at the beginning of the year and definitely closed at the end of the same year, when there should be neither credit nor debit balances. Moreover, the account is not interest-bearing.

In the capitalisation system the account is opened for the insured group when the institution begins to operate, and, although it may be audited periodically, it is never closed unless the fund ceases its operations. Deposits and payments are interest-bearing at a rate agreed in advance, which is the assumed rate. At the end of each year there must be a credit balance carried forward to the next year and constituting the actuarial reserve of the fund. These actuarial reserves, combined with the discounted value of all future receipts, must balance the discounted value of all future expenditure.

The two systems may be combined in various proportions. It may for instance be agreed to open simultaneously an annual current account not bearing interest and a perpetual interest-bearing current account, and to distribute deposits and payments between the two accounts according to definite rules.

The distinctive characteristics of the two systems are therefore that in one the operations for successive years are independent in time, while in the other they are linked up.

Nevertheless, with a view to lessening irregularity in the costs as between successive years, the system of distribution is usually amended in a way that profoundly modifies its nature. A provident reserve fund is accumulated either out of possible surplus revenue or out of a fixed deduction from contributions, which are increased for this purpose, and this reserve fund is used in case of need to avoid the levy of an extraordinary contribution. It is different from the actuarial reserves under a system of capitalisation because its amount is arbitrary, whereas an actuarial reserve must at any given time possess the appropriate value which has been mathematically calculated. In a system of capitalisation, too, provident reserve funds may be accumulated side by side with the actuarial reserves.

It will immediately be seen that the regular working of a current account in a system of capitalisation rests upon a fundamental hypothesis. Once the account is interest-bearing, the insurance fund must be able to invest the available sums at a rate of interest at least equal to that fixed for the insurance, otherwise its assets will not include the counterpart of the credit balance of the current account which, from its point of view, is a debt to the insured. Although this debt cannot be immediately claimed by the insured group, it nevertheless exists. It is what guarantees the payment of future benefits, and, if the fund were unable at any time to balance it by realisable assets, there would be no financial equilibrium.

The financial working of these two systems indicates that the system of distribution of costs is specially suited for the forms of insurance in which the annual average expenditure per insured person remains more or less constant, and the groups of persons contributing to and benefiting by the insurance coincide from the outset and during the whole course of operations. On the contrary, if there is reason to expect, either for the insured persons grouped in "risk classes" or for the whole insured group, a regular increase in expenditure from year to year, or if the insured definitively ceases to be a contributor when he becomes a beneficiary, the system of capitalisation is generally markedly superior to that of distribution of costs from the point of view of fair distribution between successive years and of the financial guarantee of the payment of benefits.

The two systems of distribution and capitalisation may take various forms according to the general principles on which the payments made by the insured are calculated.

The distribution may be carried out at the end of the year and refer to the expenditure incurred during the year, that is to say, the distribution is of actual expenditure; or it may take place at the beginning of the year and relate to the estimated expenditure for the year, that is to say, the distribution is of probable expenditure. In the second case, if the available means of estimating are considered adequate, it is possible to make the annual distribution in advance for an indefinite number of successive years. This is the method particularly suited to social insurance, at least when the insured pay a part of the contribution, for in this case the rate of contribution should not be subject to too frequent or sudden alterations.

Capitalisation is called "collective" if all the insured are required to pay the same average premium calculated in such a way that the total premiums collected or to be collected balance with the total expenditure past and future. It is called "individual" if the contribution is calculated in such a way that the probable value of the premiums to be expected from each insured person balances with the probable value of the cost of that insured person to the insurance. Each insured person strictly pays "his due", account being taken of the value of the risk. It should also be observed that the actual capitalisation is no less collective than in the system usually described by this term; only, the calculation of the premium depends on the individual characteristics of the insured with respect to the risk. Moreover, it is theoretically possible to isolate from the mass of the actuarial reserve, a particular reserve corresponding to each insured person. The individual character of the premium is to some extent transmitted to the reserve fund. It follows that a member is not indissolubly connected with the fund in which he first insured. He may leave it and join another, provided that he brings his reserve with him, and that the new fund works on terms established on the same basis as the old. Of course, if these transfers of members and reserve funds are not to interfere with the financial equilibrium of the two funds, either the number of transfers must be negligible or, if it is large, the leaving or joining of the members must not modify the estimates of the average frequency of the risk in the two groups. This is a point of prime importance to which sufficient attention is not always paid.

It may be said once for all that in normal circumstances there is no need to resort to collective capitalisation for sickness insurance, as the system becomes the same as that of distribution of costs. The position is different from that of old-age pensions, for instance, because the group covered by insurance coincides from the outset with the group entitled to benefits, and the most reasonable hypothesis possible is that the average annual expenditure per insured person should remain practically constant. Now, if the annual average premium exceeds this average expenditure, there will be a steadily growing surplus, and in the opposite case there will be a steadily growing deficit. The two must therefore be equal, which at once leads to the system of distribution.

To sum up, for social sickness insurance the choice is virtually limited to that between the distribution of the probable expenditure for the year and that of individual capitalisation. But before discussing their respective merits it is necessary to study the way in which these systems apply to sickness insurance. For the present, it need merely be remarked that the system of distribution, strengthened by the accumulation of a provident fund, is that adopted almost universally. Great Britain and Northern Ireland and the Irish Free State alone have retained the system of capitalisation, which had been started on the territory of the United Kingdom when insurance was still voluntary. As will be shown below, that system had in fact to be modified in many respects in order to be adapted to compulsory insurance.

Whatever the financial system adopted, the regular working of insurance demands that it should be possible to draw up a sufficiently accurate account of income and expenditure either in annual reports if the system is that of distribution, or for successive years regarded as bound up with each other if the system is that of capitalisation. These estimates are usually made in three stages: measurement of the intensity of the risk, estimation of the cost of the risk, determination of the rate of contributions. Moreover, these stages are not radically distinct, and the actuarial problem is complicated by the fact of their mutual dependence. Thus, in particular, the data needed to determine the risk itself vary with the legal definition of the event insured against and with the rules laid down for the granting of benefits. The demographic and economic study of the population and its probable future changes must be pursued, more or less thoroughly, in various directions, determined by the manner in which the scope of insurance is defined, by the factors entering into the calculation of

premiums and benefits, and finally by the rules of membership of the various insurance institutions. There can be no question of drawing up a general scheme even in outline. There are only particular cases to be dealt with. Only those developments will be considered here, therefore, which seem indispensable for the correct interpretation of the financial organisation of insurance in the various countries. The principal sources of information on the causes and intensity of the phenomenon of "morbidity", considered from the point of view of insurance, will be discussed first. Next—the necessary demographic and economic data being supposedly known so far as required—it will be shown how these enter into the estimation of the cost of the risk and the determination of the rate of contribution.

§ 3. — Morbidity: Factors and Measurement

MORBIDITY FACTORS

Taking only those morbidity factors which may be common to groups both wide enough and homogeneous enough to serve as a basis for statistical study, one sees them to be age, sex, occupation, and environment (climate, rural or urban life). Any wide group of persons for which these factors are identical may be considered practically homogeneous from the point of view of the risk of sickness. Of the information at present available on these factors, the least unsatisfactory is that relating to the factor of age. The data for the morbidity of women are much fewer than those for the morbidity of men, and do not lead to results of the same degree of approximation. The study of morbidity by occupations meets with well-known obstacles, common to all statistical work in which occupation is used as a criterion: the difficulty of making the definitions of occupations wide enough and yet exact enough and corresponding sufficiently to conditions in different districts or different countries, and the further difficulty of taking into account a person's changes of occupation during his economic career. As for the conditions of environment, these are usually implied in the designation of the country or place of residence of the persons composing the group observed.

There are of course several other factors to take into account: heredity, predisposition, mode of life, etc., but where the population is large enough it is quite sufficient, and in fact quite

complicated enough, to limit consideration to the factors enumerated above.

In addition to the difficulties already mentioned, there is that of defining the phenomenon to be observed. It must be clearly understood that the question is not that of the state of sickness considered from the pathological point of view, but of the state of sickness in so far as it constitutes a risk covered by insurance. This point must never be forgotten when morbidity statistics are being used. Not only does the definition of the "insurance case" depend on the law, but the interpretation given by each fund to the terms of the law and the clauses of its own rules will vary with circumstances. In particular, the interpretation may depend quite simply on the financial situation of the fund. The richer a fund is, the more likely is its sickness rate to be high, because the fund is not so strict in its examination of claims. Finally, it is a well-known fact that the morbidity of a group of insured persons depends also on other than physiological factors, such as unemployment or the difference between normal wages and cash sickness benefit.

Supposing, however, that all these difficulties have been overcome, and further that a general and infallible criterion is available by which to determine whether a given person is to be considered from the point of view of insurance to be in a state of health or not at a given date, the question then is how to measure the morbidity of a large group regarded as homogeneous which may be called "the insured group".

The mathematical theory of "recurring" risks, i.e. events which may occur to a given person on numerous occasions during his life, is very complex and does not seem to lead to biometrical functions which can be evaluated with sufficient accuracy. In practice therefore it is usually considered adequate to employ a purely empirical quantity, namely, the annual morbidity rate or average number of days of sickness per insured person per annum. If, for instance, the average number of persons in the group during the year is N and if these N persons have n days of sickness, the annual morbidity rate will be $\frac{n}{N}$. Now, the number of days "exposed to the risk" corresponding to these N persons is 365 N . The number $\frac{n}{365 N}$, which is the morbidity rate divided by 365, may therefore be considered as a measure of the

probability that any one day, taken at random among the 365 N days of risk to which the insured group are exposed, will be a day of sickness.

Another definition of the morbidity rate is sometimes given which it is useful to know, although in practice it is usually confused with the first. Instead of counting only the days of sickness of the group, the number of cases of sickness are counted as well. Let this number be C. Next assume that statistics are available showing for a group similar to that under observation the average duration in days of a case of sickness. By dividing the number of cases of sickness C by the average number of insured N, the frequency of the cases of sickness is obtained¹. The morbidity rate is then given by the product of the frequency of cases of sickness and the average duration of a sickness. This is the probable number of days of sickness with which an insured person charges the fund.

The next point to consider is in what circumstances the two definitions are identical. This happens if it is assumed, as is almost always done, that the number of days of sickness in the year divided by the number of cases in the year gives an acceptable measure of the average duration of a case of sickness. The following result is in fact obtained:

$$\begin{aligned} \text{Morbidity rate by 2nd definition} & \left\{ \begin{aligned} &= \text{frequency of cases} \times \text{average duration of a sickness} \\ &= \frac{\text{number of cases}}{\text{number of insured}} \times \frac{\text{number of days of sickness}}{\text{number of cases}} \end{aligned} \right. \\ \text{Morbidity rate by 1st definition} &= \left\{ \frac{\text{number of days of sickness}}{\text{number of insured}} \right. \end{aligned}$$

Only, it will be seen that it is not quite correct to regard the average duration of a sickness as equivalent to the number of days of sickness in the year divided by the number of cases, because a sickness may have begun before the beginning of the year or may continue after the end of the year. This point has given rise to special conventions on the method of calculating the number of cases and of days which need not be discussed in detail here.

¹ This figure is not a true frequency, for in that case it should be theoretically impossible for it to exceed unity. This is by no means so, for the number of cases may in theory, and even in practice, exceed the number of insured persons if several of them fall ill more than once during the year.

MORBIDITY TABLES

A morbidity table is one which summarises the results of the observations made for a group of insured persons during a certain period, and gives the morbidity rates at each age or in some cases for each age group (five-year or ten-year). For instance, if a table gives a morbidity rate of 5.66 days for the age of 30 years, this means that a group of insured persons who all reach 30 years about a certain date will probably charge the sickness fund during the year following that date with a number of days of sickness equal to 5.66 times the average membership of the group. Obviously the conditions of the group to which the table is applied must be sufficiently close to those of the group covered by the observations. In particular, it is necessary to know whether the observed group was selected, as in private insurance, or whether it included "good and bad risks" indiscriminately, as inevitably happens in compulsory social insurance. Further, the term "sickness" must be taken in the same sense in both cases, and, if need be, the minimum and maximum periods before and after which the days of sickness are not counted (waiting period and maximum benefit period) must coincide in both cases. The following tables are taken from the better-known morbidity tables, those which were considered sufficiently recent having been selected.

All Occupations

A. MEN

Annual Morbidity Rate in Days

Age	Kinkolin's table	Moser's table	Janse's table	Austrian table	English actuaries' table
16	6.32	6.87	—	7.6	6.57
17	6.16	6.65	—	7.8	6.44
18	6.02	6.36	—	7.9	6.21
19	5.89	5.90	—	8.2	5.94
20	5.78	5.39	4.50	8.4	5.70
21	5.68	5.12	4.55	8.3	5.52
22	5.60	4.96	4.60	8.0	5.41
23	5.53	4.88	4.64	7.7	5.38
24	5.47	4.84	4.69	7.8	5.38
25	5.44	4.85	4.74	7.9	5.41
26	5.42	4.88	4.84	7.8	5.43
27	5.41	4.98	4.93	7.8	5.45
28	5.42	5.11	5.00	7.8	5.51
29	5.44	5.25	5.08	7.8	5.58
30	5.48	5.41	5.16	7.9	5.66
31	5.53	5.61	5.26	8.0	5.75
32	5.60	5.83	5.39	8.1	5.86
33	5.68	6.05	5.50	8.3	5.96
34	5.78	6.27	5.70	8.4	6.07
35	5.90	6.48	5.91	8.5	6.20

Age	Kinkolin's table	Moser's table	Janse's table	Austrian table	English actuaries' table
36	6 03	6.67	6 11	8 7	6 34
37	6.17	6.84	6 29	8 8	6 50
38	6 33	6.99	6.45	8.9	6.69
39	6.51	7.12	6.64	9.0	6 88
40	6.70	7 24	6 84	9.2	7.08
41	6 90	7 36	6.95	9 3	7.30
42	7.12	7 49	7 10	9 4	7 51
43	7 36	7.63	7 29	9 6	7.73
44	7.61	7.78	7.45	9 8	7.94
45	7 88	7 96	7 60	10 1	8.16
46	8.16	8 18	7.75	10.3	8.41
47	8 45	8 46	7.95	10.6	8.71
48	8.76	8.82	8 22	10.9	9.03
49	9.09	9 27	8.47	11.2	9.38
50	9.43	9.82	8.70	11 5	9.77
51	9.79	10.41	9.15	11.9	10 14
52	10.16	11.02	9.60	12.2	10.55
53	10 55	11 65	10.10	12.5	10.98
54	10.95	12.28	10.77	12.9	11.47
55	11.37	12.92	11.45	13.3	12.03
56	11 80	13.56	12.20	13.7	12.59
57	12.25	14.20	12.90	14.2	13 21
58	12.72	14 84	13.67	14.8	13.85
59	13.19	15.48	14 46	15.5	14.52
60	13.69	16.12	15 34	16.2	15.25
61	14.20	16.76	16 20	16.9	16.04
62	14.72	17 40	17 00	17.7	16 86
63	15.26	18.04	17.70	18 5	17.70
64	15.81	18.68	18.48	19.0	18 55
65	16 38	19.32	19.26	19 8	19.38
66	16.97	19.96	19 95	20 6	20 26
67	17 57	20 61	20 74	21.2	21 14
68	18.18	21.26	21 80	21.9	21.99
69	18.81	21.92	23.50	22.6	22 72
70	19.46	22.59	25 80	23.2	

Notes

KINKOLIN's table (*Les Sociétés de secours mutuels de la Suisse en 1880*, Berne, 1886) is based on the experience of 919 Swiss insurance funds operating in 1880. Benefit was payable from the beginning of the sickness for a maximum period of eighteen months (one-third of the funds insured both men and women; the remainder only men)

MOSER's table (*Report to the Third International Congress of Actuaries*, Paris, 1900) is based on the experience of the Bernese Cantonal Sickness Insurance Fund during a period of some years. Benefit was granted for not more than one year. The insured persons were selected. The number of days of sickness observed was 359,341, the approximate membership of the institution was 11,000.

JANSE's table (*Report to the Third International Congress of Actuaries*, Paris, 1900) is based on the observations made from 1888 to 1897 by the Amsterdam General Sickness Fund

The Austrian table (*Krankheits- und Sterblichkeitsverhältnisse bei den Krankenkassen in den Jahren 1896-1910*¹, Vienna, 1913) together with that

¹ In spite of variations in the waiting period and the maximum period of benefit as between the funds, the Austrian actuaries considered that the differences did not appreciably affect the final result and that the morbidity rates of the table might be taken to refer to a maximum benefit period of 20 weeks and a waiting period of 8 days.

of the English actuaries, is the most interesting from the point of view of compulsory social insurance. It is based on the observations made from 1906 to 1910 for the Austrian compulsory insurance funds, covering an annual average membership of two million insured persons and a total of about ninety-five million days of sickness.

The English actuaries' table (*Report for 1912-1913 on the Administration in England of the National Insurance Act*, Part I, p. 583) is a variant of the table constructed by Watson on the basis of the experience of the "Independent Order of Oddfellows Manchester Unity" Friendly Society from 1893-1897. In the cases to which the figures here reproduced relate the maximum benefit period was six months. The first three days of sickness are excluded. (For the modifications introduced in Watson's table compare the study on the technical principles of the financial system of insurance in Great Britain in this Chapter.) Watson's table (*An Account of an Investigation of the Sickness and Mortality Experience of the I. O. O. F. Manchester Unity during the Five Years 1893-1897*, Manchester, 1903, pp. 211 and 213) covered nearly three million years "exposed to the risk", and nearly twenty-four million days of benefit, with a maximum benefit period of 26 weeks and no waiting period. It should be observed that these tables were based on a six-day week, one-sixth of the weekly benefit being paid for each working day. There is no similar experience relating to women.

Considering the diversity of the groups and the different definitions of the observed phenomenon, these tables are on the whole in remarkable agreement. It will be observed that, except in Janse's table, the morbidity rate reaches a minimum at about 25 years.

B WOMEN

Annual Morbidity Rate in Days according to the Austrian Table

Age	Excluding confinements	Including confinements	Age	Excluding confinements	Including confinements
16	6.7	7.1	44	9.5	10.0
17	6.8	7.5	45	9.8	10.1
18	7.0	8.3	46	10.0	10.3
19	7.2	9.1	47	10.2	10.4
20	7.4	10.0	48	10.5	10.6
21	7.6	10.8	49	10.8	—
22	7.8	11.4	50	11.0	—
23	8.0	11.9	51	11.3	—
24	8.1	12.1	52	11.5	—
25	8.2	12.3	53	11.7	—
26	8.2	12.4	54	11.9	—
27	8.2	12.5	55	12.1	—
28	8.4	12.4	56	12.2	—
29	8.4	12.3	57	12.4	—
30	8.4	12.1	58	12.6	—
31	8.5	12.0	59	12.9	—
32	8.5	11.9	60	13.2	—
33	8.6	11.7	61	13.6	—
34	8.6	11.5	62	14.1	—
35	8.7	11.4	63	14.6	—
36	8.7	11.2	64	15.1	—
37	8.7	11.1	65	15.7	—
38	8.7	10.8	66	16.2	—
39	8.8	10.5	67	16.7	—
40	8.8	10.3	68	17.2	—
41	8.9	10.1	69	17.7	—
42	9.1	10.0	70	18.1	—
43	9.3	10.0			

Notes

The Austrian table (*op. cit.*) is, so far as is known, the only table which is based on a sufficiently wide experience to make reproduction worth while¹. The period of observation is the same as that for the table of male morbidity. It covers an average annual membership of 650,000 insured women and nineteen million days of sickness, which figure includes about six million days for 248,070 confinements.

According to MOSER (*Report to the Third International Congress of Actuaries*, Paris, 1900), the experience of the Bernese Cantonal Fund showed that on an average the number of days of sickness for women was 37 per cent. above that for men.

Morbidity by Occupations

(a) The Austrian statistics (*op. cit.*) made it possible to draw up a morbidity table for four important occupational groups (men). It is reproduced below for five-yearly age intervals.

ANNUAL MORBIDITY RATE IN DAYS

Age	Railways	Metallurgy	Textile industry	Building
15	15.2	11.6	7.4	9.9
20	12.9	12.3	7.1	7.8
25	10.3	10.7	6.6	7.5
30	11.0	10.2	6.4	8.0
35	12.7	9.8	6.1	8.4
40	14.7	10.7	6.9	9.0
45	17.2	12.1	7.7	9.5
50	20.9	14.3	8.9	10.8
55	26.9	16.6	11.2	12.2
60	—	21.1	14.0	14.5
65	—	32.0	17.7	17.7
70	—	—	23.7	22.1

(b) The statistics of the Leipzig local fund (*Krankheits- und Sterblichkeitsverhältnisse in der Ortskrankenkasse für Leipzig und Umgegend*, published by the Imperial Statistical Office, 4 volumes, Berlin, 1910) make a detailed study of morbidity by occupation and by disease. The statistics cover 23 important occupational groups subdivided into occupations. The information on male morbidity by occupational groups is contained in Volume 2. A very small proportion of it is reproduced here, referring only to four age groups and certain occupational groups. For purposes of comparison the corresponding data for morbidity in all occupations are also given. The observations on which the statistics were based covered a period of fifteen years (1887 to 1904), about one million insured persons exposed to the risk (men only) and 9,400,000 days of sickness.

¹ The female morbidity table recently constructed by the British actuaries (see below, the study of the British financial system) is not yet to hand.

ANNUAL NUMBER OF CASES OF SICKNESS PER CENT. OF INSURED PERSONS (a)
AND ANNUAL MORBIDITY RATE IN DAYS (b) (MALE MORBIDITY)

Occupational group	Age group							
	20-24		30-34		40-44		50-54	
	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
Building	45.9	7.58	47.3	9.50	53.3	12.24	61.4	16.80
Hotel industry	28.3	6.08	27.4	6.18	36.0	10.29	44.8	15.09
Clothing	26.4	5.52	28.7	6.93	35.2	10.06	37.9	13.12
Chemical industry	45.5	7.50	45.0	8.09	51.9	11.85	52.1	13.55
Horticulture, agriculture, and forestry	34.5	3.88	37.1	6.57	46.9	11.04	64.3	15.33
Glass, china, and pottery	32.8	5.46	36.5	7.60	49.1	13.72	41.8	12.19
Metallurgy	46.7	7.76	46.3	9.34	51.6	11.85	58.7	16.37
Food industry	29.8	5.52	40.6	7.97	44.8	10.27	48.5	12.05
Stone working	46.9	7.42	50.7	13.79	61.9	17.70	67.6	24.48
Transport	33.7	5.61	38.5	7.41	49.6	11.63	60.9	16.00
Clerks and shop assistants	19.9	4.44	20.7	5.12	23.1	6.52	28.2	8.99
Engineers and stokers in all types of un- dertakings	34.1	5.63	32.4	5.75	30.9	7.62	36.6	9.21
All occupations	35.5	6.57	38.5	8.14	44.2	10.88	50.8	14.56

(c) The statistics of the Manchester Unity (Watson, *op. cit.*) contain likewise a study of morbidity by occupations. The members of the society were divided up by geographical areas, urban and rural districts, and by occupations. This last classification was composed of seven large groups.

Group A: Farmers, agricultural labourers, gardeners.

Group B: Outdoor building workers; dock labourers, canal workers, unskilled workers generally working out of doors

Group C: Railwaymen

Group D: Seamen, fishermen.

Group E: Quarrymen.

Group F: Iron and steel workers, lead and tin workers, chemical workers, glass workers.

Group G: Miners, mainly underground, but also a certain number of surface workers.

Besides these groups two others were formed:

Group H: Rural workers not included in the other groups.

Group J: Urban workers not included in the other groups.

In order to compare the morbidity of the groups, Watson brought together in a single group those whose rate seemed sufficiently alike. The table given below shows the results obtained for ages 16, 20, 30, 40, 50, 60.

ANNUAL MORBIDITY RATE IN DAYS
(Maximum Benefit Period. Six Months)

Groups	Age					
	16	20	30	40	50	60
A, H, J	6.05	5.34	5.17	6.35	8.70	13.4
B, C, D	6.89	6.14	6.18	7.88	10.74	16.3
E, F	9.10	8.04	7.74	9.44	11.56	18.6
G	10.66	8.97	9.91	12.14	16.14	23.9

Among occupational tables reference may also be made to that of S. Dumas (*Bulletin de l'Association des Actuairees Suisses*, 1911, Vol VI) based on the experience of the Relief Fund for the staff of Swiss transport undertakings from 1902 to 1908. It need not be reproduced, being of a very special nature.

For completeness, the above summary should conclude with a study of the soundness of the averages obtained; in other words, for each of the years under observation and for subsequent years the morbidity estimated from the rates in the tables should be compared with the actual figures. The question is however too wide to discuss here

§ 4. — Duration of Sickness

Statistics of the duration of cases of sickness are indispensable for determining the influence of the waiting period and the maximum benefit period on the cost of insurance.

The duration of an illness for which benefit is paid may, for instance, be divided into two periods: the first from the beginning of the sickness until the end of one year, and the second beginning at the end of the first year and continuing indefinitely. In this way two morbidity rates may be obtained by counting separately the days of sickness in respect of persons who fell ill less than a year ago and those in respect of persons who have been ill for more than a year. This is in essence the principle of the method adopted in the Watson tables.

Another method that may be used is that based on reduction coefficients. This is the term given to the number, less than unity, by which the morbidity rate must be multiplied to obtain the number of days of benefit, provided that the waiting period and the maximum benefit period are known. The reduction coefficients may be calculated from the statistics of the duration of sicknesses, i.e. statistics showing, for instance, for a thousand cases of sickness how many cases last one day, two days, etc.; one week, two weeks, etc.; one month, two months, etc.

Reference may be made to Moser's reduction table (*Third*

International Congress of Actuaries, Paris, 1901, p. 664) giving the reduction coefficient to be applied to the morbidity rates for benefit periods of up to one year, the maximum period being one year and benefit being payable from the beginning of the sickness.

Period of benefit	Reduction coefficient	Period of benefit	Reduction coefficient
Weeks		Weeks	
0	0 000	10	0 784
1	0 237	11	0 801
2	0 403	12	0 817
3	0 508	13	0 830
4	0 582	17	0 872
5	0 637	21	0 902
6	0 678	26	0 928
7	0 712	39	0 973
8	0 739	52	1 000
9	0 763		

Janse (*ibid.*, p. 150) has deduced, from the observations on which the morbidity table already quoted was based, reduction factors in respect of the different waiting periods and maximum benefit periods (number of days of benefit per thousand days of sickness).

DAYS OF BENEFIT PER 1,000 DAYS OF SICKNESS

Day on which right to benefit begins	Maximum benefit period in days										
	20	30	40	60	90	120	150	180	300	365	Unlimited
1st	375	470	540	637	724	781	822	862	940	961	1,000
2nd	347	442	512	609	696	753	794	834	912	933	972
3rd	317	412	482	579	666	723	764	804	882	903	942
4th	294	399	459	556	643	700	741	781	859	880	919
5th	270	365	435	532	619	676	717	757	835	856	895
6th	246	341	411	508	595	652	693	733	811	832	871
7th	223	318	388	485	577	629	670	710	788	809	848

The *Report for 1912-1913 on the Administration in England of the National Health Insurance Act*¹ contains a detailed study on the duration of cases of sickness. There are in particular two tables based on the experience of the "Manchester Unity" Friendly Society (1893-1897). The first gives the distribution of cases of sickness by duration for those which have lasted over two years;

¹ Part I (Health Insurance), London, 1914. This report contains information of the highest interest on the actuarial bases of sickness insurance (pp. 16-36 and 552-601).

the other gives the corresponding morbidity rates in weeks when the maximum benefit period varies from 0 to one year. The second table is reproduced in part, being more adapted to the ordinary definition of sickness, whereas the first refers rather to disablement.

ANNUAL MORBIDITY RATE IN WEEKS FOR DIFFERENT
BENEFIT PERIODS

Benefit period	Age					
	16	20	25	30	35	40
Weeks						
1	0.250	0.200	0.183	0.184	0.188	0.194
2	0.415	0.345	0.319	0.318	0.328	0.343
3	0.540	0.455	0.417	0.420	0.434	0.459
4	0.637	0.538	0.491	0.495	0.514	0.548
5	0.712	0.599	0.543	0.548	0.572	0.615
6	0.770	0.644	0.580	0.586	0.615	0.665
7	0.813	0.676	0.608	0.615	0.648	0.703
8	0.846	0.699	0.630	0.638	0.674	0.733
9	0.871	0.717	0.648	0.657	0.696	0.759
10	0.891	0.732	0.663	0.673	0.715	0.782
11	0.907	0.744	0.675	0.687	0.732	0.803
12	0.920	0.764	0.685	0.700	0.747	0.822
Months						
3	0.930	0.768	0.695	0.712	0.761	0.840
6	0.984	0.838	0.788	0.816	0.885	0.999
12	1.005	0.879	0.847	0.885	0.974	1.122

Benefit period	Age					
	45	50	55	60	65	70
Weeks						
1	0.204	0.218	0.236	0.256	0.276	0.290
2	0.367	0.398	0.436	0.478	0.520	0.550
3	0.496	0.543	0.601	0.666	0.732	0.780
4	0.596	0.657	0.731	0.821	0.913	0.980
5	0.673	0.745	0.838	0.946	1.067	1.148
6	0.731	0.813	0.920	1.047	1.190	1.290
7	0.776	0.867	0.987	1.132	1.297	1.412
8	0.813	0.911	1.043	1.204	1.391	1.520
9	0.844	0.949	1.092	1.268	1.476	1.622
10	0.871	0.983	1.137	1.327	1.555	1.720
11	0.896	1.015	1.179	1.383	1.631	1.815
12	0.919	1.045	1.219	1.437	1.705	1.908
Months						
3	0.940	1.073	1.257	1.490	1.778	2.000
6	1.140	1.343	1.634	2.047	2.570	3.054
12	1.304	1.571	1.990	2.611	3.534	4.537

Finally, there is Toja's table of reduction coefficients (for 1,000 days of sickness) based on the experience of the Italian mutual aid societies from 1881 to 1885 ¹.

DAYS OF BENEFIT PER 1,000 DAYS OF SICKNESS

Day on which benefit begins	Maximum benefit period in days			
	90	180	365	Unlimited
1st	919	978	995	1,000
2nd	876	935	952	957
3rd	833	892	909	914
4th	790	849	866	871
5th	748	807	824	829
6th	709	768	785	790
7th	671	733	750	755

With these tables it is possible to determine the effects on insurance costs of fixing the waiting period and the maximum benefit period. Supposing, for instance, that the cash benefit is one franc per day of sickness and that the maximum benefit period is six months, what saving may be effected by increasing the waiting period from three to five days? If the expenditure is a thousand francs for a waiting period of three days, then for a waiting period of five days

the expenditure according to Janse's table will be :

$$1,000 \times \frac{733}{781} = 939 \text{ francs ;}$$

the expenditure according to Toja's table will be :

$$1,000 \times \frac{768}{849} = 905 \text{ francs.}$$

That the results differ so much is not surprising, considering the diversity of the groups on which the observations are based. Moreover, in calculations of this kind it must not be forgotten that the reduction coefficients are established on the assumption that the change in the waiting period does not affect the morbidity rate itself. This is not the case, however, because to some extent the insured persons tend to prolong their incapacity until the day on which they are entitled to benefit.

¹ MINISTERO PER L'INDUSTRIA, IL COMMERCIO ED IL LAVORO. *L'assicurazione obbligatoria contro le malattie*, p. 113. Rome, 1920.

§ 5. — Evaluation of the Cost of the Risk : Determination of the Rate of Contribution

If the obligation of the insurer could be limited to a fixed rate of benefit per day of sickness, a reliable morbidity table would be all that would be wanted to make the evaluation of the cost of insurance the simplest problem in the world. But this is by no means the case. An important part of the expenditure, and one which has steadily grown in relative importance during the last few years, is that relating to benefits in kind: medical fees, drugs, hospital treatment, preventive measures, and social hygiene. This expenditure is perhaps the most interesting because the most productive; but it has often been claimed that benefits in kind do not lend themselves well to accurate estimation, particularly in periods of rapid price fluctuation. It may, however, be urged that the difficulties and the risk of financial unsoundness for insurance funds arising from the provision of benefits in kind have been much exaggerated. If prices rise and are followed by a rise in wages, the increase in the cash sickness benefit will be compensated by a corresponding increase in contributions, assuming that both are fixed in proportion to wages. Admittedly, wages lag more or less behind the general rise in prices; but it should be pointed out that this lag applies not only to the wages of the insured, but also to doctor's fees and the salaries of hospital staffs and the workers employed in the manufacture and preparation of drugs, or, in other words, to an important fraction of the cost of benefits in kind.

Setting this problem aside, and assuming that the average cost of benefit in kind per insured person per year is known with the greatest possible accuracy, one may pass to the next problem, which is to determine the cost of insurance under the systems of distribution and individual capitalisation respectively, and the manner of deducing therefrom the rate of contribution.

DISTRIBUTION SYSTEMS

Once the distribution of the insured persons by ages or by age groups is known, as well as the appropriate morbidity rates, it is easy to deduce the cost of insurance if the cash benefit is independent of wages. If, on the contrary, it varies with wages, it is also necessary to know the distribution of the insured with respect to wages.

Methods of Distribution

Assuming that the total cost of insurance, including administrative expenses, is fixed, how is it to be distributed among the insured? There are three obvious methods:

(1) In the first place, recourse may be had to an "equal" distribution, that is to say, the total expenditure may simply be divided by the number of insured. This gives a fixed contribution independent of wages. But the system is rarely used in social insurance, which covers workers at various rates of pay and differently exposed to the risk of sickness.

(2) The expenditure may be distributed in proportion to the morbidity rates. If the cash benefit is independent of wages, this gives a sort of "risk premium". If the benefit varies directly with wages, the corresponding expenditure will be distributed in proportion both to the morbidity rate and to the wage rate. This is the most suitable method for a private undertaking operating on the annual distribution system. On the other hand, it is in no way appropriate to social insurance, so far as it is held that the principle of mutual aid, on which such insurance must be based, requires the alleviation of the burden of the poorest members of the fund and those most exposed to the risk.

(3) The procedure adopted almost universally is that of distributing expenditure in proportion to wages alone. In this case there is at least an attempt to adjust the burden to the ability to pay. It follows that if the risk premium is considered to be the fair cost of insurance, the members of the fund who are best off and least exposed to the risk help to "relieve" the others. The extent to which they do so will be examined later.

Influence of the Gravity of the Risk

Nevertheless this method cannot be applied uniformly in all cases. If for a small group of insured persons the "value of the risk" is much higher compared with the average for other groups, the distribution in proportion to wages may be amended by raising the coefficient for that group. This is known as establishing an "extra risk premium". It should be remarked that it is neither necessary nor desirable that in every case such an extra premium should finally fix for the group under consideration the risk premium considered appropriate to it. So far as social insurance is concerned, the gravity of the risk should not be allowed to enter

into the determination of the contribution save as an exceptional and suitably graduated measure.

Disregarding these particular cases, one may assume that the distribution is in proportion to wages, and also that the cash benefit is itself fixed as a certain percentage of the wage. The question then arises how to classify the insured by their wages for insurance purposes.

The Maximum Wage

A fundamental point must first be considered: the question of the maximum wage. This question has three separate aspects. There may be a maximum wage for the definition of the scope of insurance, i.e. a wage above which the workers cease to be compulsorily insured. There may be a maximum for the insured wage, i.e. a limit above which wages are not taken into account in calculating the cash benefit. Finally, there may be a maximum for the assessable wage, i.e. a limit above which wages are not taken into account in fixing the contribution.

The first aspect of the question may be left out of account (see Part I), because if only the system of so-called "workers' " insurance is considered, there is no reason to fix a maximum in the sense described.

As for the insured and assessable maximum wages, it will be assumed that the two limits coincide. It would, in fact, be difficult for this not to be so, although it is not absolutely necessary. But in point of fact an insured person whose wages are above either or both of the two limits would find it difficult to understand why his contribution and his sickness benefit should be calculated on different sums.

The determination of this maximum has a twofold effect. In the first place, it influences the "compensatory " value of the cash benefit for members with high wages. Secondly, it influences not only the amount of the funds available for insurance purposes, but also the actual results of distribution. For according as the maximum fixed by the law falls towards the average wage, there is an increase in the number of insured persons who for classification purposes are counted, though in a varying degree, at a lower rate than their actual wage. It follows that, in so far as the system of classification aims at adapting the premium to the ability to pay, it fails in its purpose, and all the more so the higher the number of persons above the maximum. The choice of the maximum is

therefore a very delicate operation, especially in a period of fluctuating prices, and it is desirable to have it revised frequently.

It may well be asked why in these conditions a maximum assessable wage should be fixed at all. In fact the arguments produced in its justification scarcely apply to workers' insurance properly so called, and are not fully effective unless the insurance system includes, for instance, highly-paid salaried workers. In this case, assuming that the assessable and insured maxima coincide, the fund might find itself in the position of the insurer who divides his risks badly, i.e. who undertakes too heavy an obligation compared with the small number of risks. A chance deviation, in the direction unfavourable to the fund, of the morbidity of this group of insured might upset the whole system of distribution. Moreover, the point would soon be reached at which the insurance of this group would become too burdensome. As already explained, however, these arguments do not apply in the case of workers' insurance, where the range of wages covered is relatively narrow.

Assuming, however, that the common maximum of the insured and assessable wages has been fixed in the best interests of both insurer and insured, the next point one has to consider is the classification of the insured by wages up to the limit and to deduce a method of assessment.

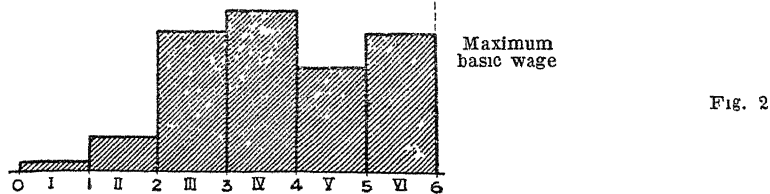
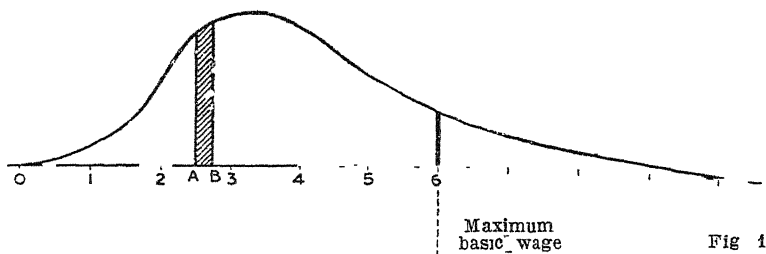
Wage Classes

The simplest, and at the same time fairest, system seems that of taking into account the wages actually earned, up to the maximum. In fact this method is quite often used, and then the contribution for each insured person is expressed as a percentage of his true wages.

But if it is considered too difficult to obtain from the employer or the wage-earner declarations which are sufficiently frequent and exact for the strict application of this method of assessment, recourse will be had to dividing the insured into wage classes.

The classification of the insured from zero wages to the maximum wage and above may be represented by such a graph as that in the figure below (fig. 1). In this graph the horizontal axis represents the amount of wages, and the height of the vertical segment comprised between the wage axis and the curve represents the frequency of the corresponding wage. For instance, if the point A corresponds to a daily wage of 25 francs, and the point B to a daily wage of 27 francs, the number of insured persons in receipt of wages between 25 and 27 francs is represented by the shaded area.

The problem of devising wage classes then becomes that of substituting for the "continuous" representation of wage frequency as illustrated by the graph A, a "discontinuous" representation as shown in fig. 2, based on the following principle. The wages are divided into a number of groups at certain intervals, which for simplicity are considered equal, although they need not be. For each of these divisions there is a corresponding wage class defined by a lower and a higher limit. This class consists of the insured persons whose true wages are comprised within the two limits, a convention having been adopted to decide the class in which to



place those whose wages coincide with either of the limits. Further, the class whose upper limit is the same as the maximum wage will include all the insured persons whose true wages exceed the maximum (this may have the result, as in the example used, of placing a larger number in the last class than in the one just before). The contents in each class may then be represented by a rectangle whose base is the segment of the axis corresponding to the class and whose area is proportionate to the number of insured.

Next, in the wage interval for each class, a certain wage rate is chosen, called the basic wage of the class, on which the contribution of all the insured persons in the class is calculated. In other words,

the insured in that class are treated as if they all earn the same amount.

It will be seen, firstly, that the larger the number of wage classes, the closer the result will be to the representation corresponding to reality; and, secondly, that the closer the basic wage in each class is to the upper limit of the class, the greater will be the yield of a given rate of contribution, but at the same time the more will the lower wages in the class be placed at a disadvantage. Moreover, variations in the yield or in the relative assessment of the insured in any one class, due to the choice of the basic wage, become smaller as the number of wage classes increases.

Thus from every point of view it would seem desirable to make the number of wage classes very large. But it is soon found that this process may mean the loss of the very advantages to be drawn from the system of classes: simplicity in the formalities of registration, notification, and control; relative stability in the classification of the insured.

An imaginary illustration may be taken to give an idea of the effect of the subdivision into classes. Assume that the monetary unit is the lowest wage to be taken into account and that the other wage rates may be expressed with sufficient accuracy as multiples of the unit. If the maximum wage is 16 units and the number of insured is 100,000, their distribution may take the following form:

Wage in units	Number of insured	Wage in units	Number of insured
1	150	9	11,900
2	350	10	12,900
3	500	11	12,900
4	1,300	12	11,900
5	2,500	13	9,300
6	4,400	14	6,700
7	6,700	15	4,400
8	9,300	16 or over	4,800

If there is no grouping into wage classes, the total assessable wages amount to 1,046,050 units (as compared with 1,050,000 units if no maximum wage is fixed, assuming that the distribution is symmetrical about the 10.5 wage).

Now form eight wage classes by combining the previous groups in pairs. The following distribution is then obtained:

Wage class	Number of insured
1st	500
2nd	1,800
3rd	6,900
4th	16,000
5th	24,800
6th	24,800
7th	16,000
8th	9,200

The total assessable wages will then vary with the choice of the basic wage as follows:

Basic wage in each class	Total assessable wages	
	Units	Per cent of "true" total
Lower limit	994,400	95
Median	1,044,400	99.8
Upper limit	1,094,400	104.6

If the contribution were fixed at 5 per cent. of the top wage in each class, the contribution of the least-paid insured persons in the fourth class, for instance, would actually represent 5.71 per cent. of their wages.

A still rougher subdivision is obtained if the above wage classes are combined in pairs. This gives the following distribution:

Wage class	Number of insured
1st	2,300
2nd	22,900
3rd	49,600
4th	25,200

The total assessable wages will this time vary with the choice of the basic wage as follows:

Basic wage in each class	Total assessable wages	
	Units	Per cent of "true" total
Lower limit	890,800	85.00
Median	1,040,800	99.50
Upper limit	1,190,800	114.00

With a contribution of five per cent. of the median wage in each class, the actual rate of contribution for the least-paid insured persons in the third class, for instance, would be 5.83 per cent. of wages.

This example, which is given purely as an illustration, is intended to bring out the "play" of the wage classes and the size of the variations which may be expected. It is obvious that the facts may be different, especially at present when the distribution of wages seems to be far from symmetrical.

The Basic Wage and Rate of Contribution

The basic wage is defined as the sum, whatever it may be, fixed either by law or by the rules of the funds on which the contribution of each insured person is calculated.

Summing up and completing the particulars just given, four fundamental types of basic wage may be distinguished:

(1) The basic wage may be the true wage up to the maximum limit.

(2) If the insured are divided into wage classes, the basic wage may be a certain rate selected for each class between the limiting wages of the class or even equal to one of the two limits. Although the description is not always exact, it is then often said that the basic wage is the average wage of the class.

(3) If the wages of the insured persons do not differ very widely, they may be placed in a single wage class, and a basic wage may be fixed common to them all to be regarded as the average wage of the group.

(4) Finally it may happen that none of the above methods can be easily applied to certain groups of insured whose economic career is difficult to follow. Or else it may be found simpler to avoid all formalities of notification as well as of checking wages. In these cases the basic wage of the insured persons (classified if need be by sex or into the more important age groups or occupational groups) will be fixed periodically by decision of the local authorities in such a way as to make it as close as possible to the average wage obtaining. For this reason this method will be described as that of the local wage.

In a word, the basic wage may be the true wage of each insured person, the average wage in each wage class, the average wage of the insured group, or the local wage.

The rate of contribution will then be a percentage of the basic

wage. Actually, it is as a rule impossible to fix the rate by law unless the financial unit is a single fund covering the whole insured population. If there are several funds enjoying financial autonomy whose membership varies in composition, being seldom a microcosm of the whole insured population, all that the law can reasonably do is to define the limits between which the responsible authorities are to fix the rate of contributions.

Mutual Aid by Distribution in Proportion to Wages

The discussion of the question of wage classes will serve to show how to attack another problem already referred to, that of the degree of the "relief" which some of the insured give the others in consequence of the system of distribution in proportion to wages.

An imaginary example may again be taken, relating to a group of 130,000 insured persons classified in ten-year age groups and wage classes as shown in the table below:

Basic wage	Wage class									Number of insured in each wage group
	I	II	III	IV	V	VI	VII	VIII	IX	
	1	1.5	2	2.5	3	3.5	4	4.5	5	
Age group										
16-25	2,130 <i>40</i>	4 890 <i>22</i>	6,640 <i>8</i>	7,520 <i>2</i>	7,150 <i>11</i>	5,770 <i>18</i>	4,020 <i>24</i>	2,380 <i>29</i>	1,500 <i>33</i>	42,000
26-35	500 <i>36</i>	1,930 <i>17</i>	3,450 <i>3</i>	4,980 <i>9</i>	5,680 <i>18</i>	6,100 <i>25</i>	5,080 <i>32</i>	3,350 <i>37</i>	1,930 <i>42</i>	33,000
36-45	30 <i>45</i>	500 <i>29</i>	900 <i>16</i>	1,500 <i>7</i>	2,670 <i>1</i>	4,100 <i>8</i>	4,890 <i>13</i>	5 340 <i>18</i>	5,070 <i>22</i>	25,000
46-55	50 <i>56</i>	500 <i>43</i>	740 <i>33</i>	1,340 <i>25</i>	2,150 <i>19</i>	3,100 <i>14</i>	3,760 <i>10</i>	4,000 <i>6</i>	3,360 <i>3</i>	19,000
56-65	130 <i>69</i>	530 <i>60</i>	1,100 <i>53</i>	1,600 <i>47</i>	1,900 <i>42</i>	2 000 <i>39</i>	1,000 <i>46</i>	400 <i>33</i>	340 <i>31</i>	9,000
66-75	100 <i>78</i>	200 <i>72</i>	430 <i>67</i>	550 <i>63</i>	400 <i>60</i>	200 <i>57</i>	70 <i>55</i>	30 <i>53</i>	20 <i>52</i>	2,000
Number of insured in each class	2,940	8,550	13,260	17,490	19,950	21,270	18,820	15,500	12,220	130,000
Annual contribution in each class	15	22.5	30	37.5	45	52.5	60	67.5	75	

The figures in ordinary type give the number of insured in each age group and wage class.

The italic figures give the difference between the risk premium and the contribution expressed as a percentage of the former. The risk premium is higher than the contribution for the insured groups shown to the left of and below the blackline; it is lower than the contribution for those shown to the right of and above that line. The basic (daily) wage of Class I is taken as the monetary unit.

The general age distribution corresponds roughly to that of the Vienna *Allgemeine Arbeiter-Kranken- und -Unterstützungskasse* for 1925. The age distribution for the separate wage classes is

purely theoretical and neither more nor less plausible than many others that might be imagined.

The monetary unit chosen is the basic (daily) wage of the lowest class, and there are nine wage classes, the basic wage rising regularly by 0.5 unit. It is assumed that a contribution of five per cent. of the assessable wage covered insurance costs without surplus or deficit, that two-fifths of the expenditure was on benefits in kind and three-fifths on cash benefits proportional to the basic wage. The annual amount of the contribution in each wage class when the distribution is in proportion to the basic wage is shown in the last line of the table, assuming that there are 300 contribution days in the year.

The italic figures below the number of insured persons in each group show the difference between the risk premium and the contribution as a percentage of the premium¹. This difference is positive (risk premium higher than contribution) for all the groups to be found to the left of or below the black line in the table, and negative (risk premium lower than contribution) for the other groups. The persons in the first set of groups are "assisted" by those in the second set, and the figures show the extent to which the contribution of each person represents either more or less than the "fair cost" of insurance. There are in all 77,530 persons, or 60 per cent. of the total, whose contribution exceeds the fair cost. The "assisted" persons comprise young members with low wages and all insured persons of over 46 years of age whatever their wage class.

Although the illustration is imaginary, a real distribution would no doubt in most cases give figures of similar order to those shown, at least where the proportion between benefits in kind and in cash is about the same, and the age variations in morbidity are comparable. The difference should not be great unless the distribution of the insured by age groups or wage classes is exceptional (abnormally high or low average age; several wage classes practically empty).

Reserve Funds in Distribution Systems

It has already been stated that the system of distribution of costs is usually amended to its advantage by the accumulation

¹ The risk premium is calculated by classifying the costs of benefits in kind in proportion to the morbidity rate (central rates derived from the Austrian table) and the costs of cash benefits in proportion to both the morbidity rate and the basic wage.

of provident reserve funds. Some account must be given of the constitution, amount, and objects of these reserves.

The reserve fund may be accumulated out of chance surpluses of annual revenue. This simple procedure cannot produce appreciable and sufficiently regular results unless there is a considerable loading of the contribution with this object. It is more reasonable to fix on a sum to be deducted annually out of contributions and devoted to forming a reserve fund, nor would this prevent the inclusion of any surplus revenue. The proportion very often fixed by law for the deduction is one-twentieth of the contributions.

The problem of what minimum should be fixed for the constitution of the reserve fund cannot be clearly settled by theoretical considerations. From a purely empirical point of view, it seems as if the reserve fund will begin to play an effective part in preserving financial equilibrium when its amount is of the same order as the annual expenditure. In practice this is the kind of criterion adopted in most laws which fix a statutory minimum for the reserve fund. As for the maximum, that is to say, the sum above which the insurance funds are forbidden to raise their provident reserves, the following considerations have usually been taken by the legislature as a guide in fixing the amount: the desire to avoid immobilising too large sums; the desire to avoid the existence of funds which are too rich and therefore tend to be extravagant and careless in checking claims, and whereby objectionable inequalities arise between the benefits granted by the various funds. Finally, it must not be forgotten that the reserve fund acts as a sort of link between the accounts for the separate years, although this function is not established on technical grounds as in capitalisation systems. Hence, when the reserve fund is too large, the insured are in effect living on the sacrifices of their predecessors from which the latter have themselves drawn no advantage.

On the supposition that the minimum reserve fund is to be equal in amount to the annual expenditure, what time will be needed to accumulate it? If it is assumed that it is to be accumulated out of one-twentieth of the contributions, and that the remaining nineteen-twentieths precisely cover the (constant) expenditure of each year, and if the sums placed to reserve are invested at an average annual rate of five per cent., then the reserve fund will not begin to exceed the statutory minimum until the commencement of the fourteenth year. Of course this result assumes that during the whole period there has been no deduction from the fund or the interest on it.

The point to which it is desired to draw attention is that the constitution of a provident fund of adequate amount within a reasonable period is not necessarily a simple matter for an insurance fund which does not wish to make its contributions too heavy.

The final question is that of the objects of the reserve fund. It has three essential functions:

(1) Sums may be drawn from the fund to reduce or cancel the effects of chance fluctuations in expenditure from year to year.

(2) The same method may be used to cope with exceptional increases in the intensity of the risk (epidemics). This assumes that the fund is already comparatively large. It might even be advisable to separate these two functions and to create a special fund for particular emergencies (emergency fund). This would mean two reserve funds, one to counteract slight fluctuations from year to year, the other to counteract larger fluctuations covering a longer period than the financial year.

(3) Apart from any sums drawn from the actual capital of the fund, the interest adds a regular contribution to the annual revenue. To take the example already given, assume that the fund has reached the minimum and is left at that level, and that the annual expenditure remains constant; by how much will the contribution be reduced? In the first place by the deduction of one-twentieth which will no longer be needed, and secondly by the interest of five per cent. on the remaining nineteen-twentieths which by hypothesis represent the amount of the reserve fund. In other words the total reduction of the original contribution is one of not much less than 10 per cent.

SYSTEMS OF INDIVIDUAL CAPITALISATION

Present Value of the Cost of the Risk

The calculation of the cost of the risk in a system of individual capitalisation rests on two more hypotheses than those required for a system of annual distribution of probable expenditure, but usually dispenses with one other.

In the first place a rate of interest must be chosen corresponding to the estimates of the probable yield of investments in future years. Secondly, a mortality table applying to the insured group is necessary. The object being to estimate the present value of the

probable costs relating to an insured person during the whole of his life, it is evident that this value will depend on his expectation of life when he enters into insurance. But, thirdly, in a system of individual capitalisation there is at least no theoretical reason for studying the demographic and economic composition of each insured group. Only the data for the whole insured population are needed. In other words, instead of using the considerations based on real societies which are necessary in the system of distribution, the technique of individual capitalisation substitutes the consideration of imaginary societies in each of which the units are similarly exposed to the risk. This is why the system is by far the best suited to private insurance, which cannot make precise estimates of the size and composition of its clientèle and must propose rates of insurance drawn up on commercial bases.

Suppose that the rate of interest is fixed and a mortality table chosen. Take the case of a person who entered into insurance at a certain age, for instance, 30 years. The obligation of the insurer towards that person for the tenth year, for instance, following his entry into insurance is obviously equivalent to the present value of a capital sum in respect of a person now 30 years of age, deferred by ten years and equal in amount to the product of the morbidity rate (in days of sickness) at the age of 40 and the daily cash benefit. If the present values of the deferred capital sums corresponding to each year of the insurance are added together for all years to come, the probable present value of the cost of cash benefit is obtained.

It will at once be seen that individual capitalisation is unsuitable for the forms of insurance in which the cash benefit varies with wages. It is in fact impossible to foretell with sufficient accuracy the maximum and minimum wages earned by a worker during his economic career, and this financial system is appropriate only where the benefit is a contractual sum fixed uniformly for the whole life of the insured person.

The table given below, based on the tables calculated by Watson from the data for the "Manchester Unity" Friendly Society from 1893 to 1897, shows the probable present value of a weekly sickness benefit, supposed equal to the monetary unit, for the different ages at which a person enters into insurance, assuming that he remains insured throughout his life and that the rate of interest is four per cent.

PRESENT VALUE OF BENEFIT OF ONE UNIT PER WEEK OF
SICKNESS

Present age at entry into insurance	Maximum benefit period		
	3 months	6 months	Unlimited
Years			
16	17.92	21 38	38.48
20	17.36	21 19	41 25
30	17.87	22.65	52 06
40	18.58	24 58	67 44
50	18.56	25 91	88 28
60	16.89	25.25	115 48
70	12.08	19 69	141 37
80	5 82	10.22	132.27

The table illustrates the combined influence of the rate of interest, rate of mortality and rate of morbidity. If a person enters insurance while young, the ages of high morbidity rates—which he may not even reach at all—is distant. The expenditure represented by that age is reduced by a considerable life discount. Then the age of entry approaches that of maximum morbidity; the effect of the discount becomes less and less and the cost of insurance rises. Finally, a point is reached at which the mortality rate is the predominant factor: the expectation of life falls rapidly, and at the same time, in spite of increasing morbidity, there is a fall in the present value of the cost.

Annual Premium

The previous discussion will have shown what the probable present value of the total cost of insurance will be according to the age of entry into insurance. It is the lump sum which the insured person would have to pay on a single occasion (single premium) to be free of all obligations towards the insurer.

In order to deduce the annual premium from this sum, i.e. the amount of the annual payments which together will be equivalent to the single premium, it is sufficient to divide the latter by the sum of the probable present values of unity at the beginning of the successive years of the insured person's life. This will give the annual contribution, which thus also varies with the age of entry into insurance, and for two reasons: in the first place because the

single premium already depends on that factor; and, secondly, because the value of the annual payments discounted by the insurance fund will depend on the expectation of life of the insured person to whom they relate.

Thus, on the basis of Watson's tables and a four per cent. rate of interest, the annual premium payable in order to obtain a daily benefit of five francs (weekly, 35 francs) at any time during the life of the insured will be as follows for the successive ages of entry into insurance shown:

Age of entry into insurance Years	Maximum benefit period		
	3 months	6 months	Unlimited
16	29.9	35.7	64.2
20	29.9	36.5	71.0
30	33.7	42.6	98.8
40	40.0	53.0	145.3
50	48.4	67.6	230.3
60	58.1	86.8	397.1

This table relates to the simple premiums without any loading for security or administrative expenses. Moreover, it is clear that if the payments are made in instalments, the weekly premium for instance will not be obtained by simply dividing the annual premium by 52. The discount during the course of the year has to be taken into consideration; but it is unnecessary to examine these technical details here.

The chief point of interest brought out by the table is the rapid increase in the premium as the age of entry into insurance rises, particularly if the benefit is payable for the whole duration of the sickness. Consequently, if it is desired in a system of social insurance not to place an excessive burden on persons who enter after their twentieth year, some method must be devised for amending the system of individual capitalisation.

Finally, attention may again be drawn to the point that individual capitalisation, being based on the hypothesis of contractual benefit, necessarily leads to a fixed contribution rate independent of wages. There is, therefore, no need for wage classes or basic wages, and this means an appreciable simplification of the administration of insurance. On the other hand, there is no attempt to adjust either benefits or contributions to the workers' wages.

It also becomes clear why capitalisation is specially suited to

social insurance if the system is based on the principle that the insured are completely free to join the insurance institution of their choice. In a system of distribution, if the cash benefit is fixed, the younger groups will ordinarily have to come to the assistance of the older groups. If they are allowed to form the societies they prefer, they will therefore leave the funds in which there are old members. But when they in turn grow old they will be alone in having to bear heavy insurance costs, and that at an age when their resources are usually declining. This will result in a lack of equilibrium which must prejudice both the working of the insurance and the interests of the insured. Capitalisation, on the contrary, levels the burden of insurance from one year to another throughout the life of the insured, and a young member is no longer placed at a disadvantage by having older members beside him. Moreover, if the first few months of working are left out of account, the vast majority of persons entering each year will be recruited from the younger generation, and the system will be perfectly logical and sound. All that is necessary is that special measures should be taken for persons who enter into insurance when the system is first started, at ages no longer very close to the lower age limit. Such measures will presumably be continued for persons entering in subsequent years, but will no doubt merely affect an almost negligible minority.

Actuarial Reserves

As the premium for each insured person is levelled from one year to another while the risk continues to grow¹, it follows that at first the contribution exceeds the annual value of the risk and later falls below it. The capitalised surpluses derived from the first years' premiums are subsequently consumed by degrees in order to meet the deficits due to the shortage of the premiums in the last years. At any moment they constitute the actuarial reserve in respect of the insured person. This reserve is equal to the difference between the present values of the obligations of the insurer and those of the insured. This must be so, because the reserve plus the present value of the premiums to be collected (obligations of the insured) must at any moment balance the present value of prospective benefits (obligations of the insurer). Thus in the system of individual capitalisation there is an actuarial reserve corresponding to every moment in the career of an insured person,

¹ At least after about the 25th year of age.

which is perfectly well defined once the conditions of insurance have been fixed, and may be calculated theoretically with the same precision as the premium.

The following table gives as an example the reserves at different ages for a person who enters into insurance at the age of 16 years, the figures being calculated from Watson's tables at a four per cent. rate of interest (daily sickness benefit five francs for a maximum period of six months, with a constant annual premium determined in advance).

Years in insurance	Age of insured	Reserve
4	20	16.5
14	30	131.3
24	40	280.7
34	50	428.1
44	60	520.5
54	70	488.9
64	80	198.5

Fragmentary though these figures are, they show the period during which the reserve increases by all the surpluses contained in the annual premium, and then that during which it begins to be used up to supplement the premium.

Another reason why individual capitalisation is suitable in a system of free affiliation is now clear. Suppose that a person who entered into insurance at the age of 16 years leaves his fund at the age of 30. All that the fund need do is to pay into his new society the sum of 131 francs in order that the latter may be able, so to speak, to take over the insured at the point at which he left the old fund. This indicates the reason and nature of transferances of reserves.

Further, the table of reserves suggests a means of equalising the contributions whatever the age of entry, and of bringing them all to the level of the contribution corresponding to a person who begins his payments at the age of 16 years. Take, for instance, a person who does not enter into insurance until he is 40 years old. He ought to pay an annual premium of 53 francs; it is wished not to ask more of him than 35.70 francs as if he had entered at the age of 16. This will be possible if there is some means of crediting to the fund when he enters a sum equal to the reserve which would have been constituted if he had paid contributions since he was 16 years old, or in this particular example the sum of 281 francs. As on the other hand it is not desired to make the member pay this "entrance fee", this is precisely the point at which the system of individual capitalisation must be given up, at least with respect

to the past. In order to meet this liability recourse might be had to collective capitalisation. Or a simple system of annual distribution might be used. Or else the whole responsibility for paying the entrance fee might be placed on the State. There are many possible solutions. In the study of the various laws an account will be given of that adopted in Great Britain.

A few more remarks may be made in order to complete the differentiation of the system of capitalisation and that of distribution of costs.

Capitalisation being a "long-term" financial operation, the soundness of the whole system, unlike that of distribution, will be compromised by marked or repeated changes in the rates of interest, mortality or morbidity. The technical and actuarial data must therefore be examined critically at frequent intervals, the facts compared with the estimates, and the total assets and liabilities frequently estimated in the light of recent experience. For a risk like that of sickness, which is less known and no doubt intrinsically less stable than mortality, such revisions will usually lead to a modification in some part or other of the financial system, and it must not be supposed that a contribution rate based on capitalisation will be much more protected against adjustment than that in a system of distribution.

Further, the system of capitalisation lacks flexibility compared with that of distribution. Any alteration in the law which changes the respective obligations of the parties during the course of the contract between them reacts on the practically unlimited series of future financial years which are all interlocked. If, in spite of these uncertainties and complications, the system has many authoritative advocates, the reason must be sought either in the desire to maintain a certain similarity between the financial management of social insurance and that of private insurance, or in the facility with which it can be adapted to the principle of free affiliation. Moreover, any system of insurance must feel its way to begin with. It is only practical experience that can bring out the particular features of the risk insured against and any recurrent factors. It may be added that in systems of insurance covering indifferently both sickness and invalidity, there is a natural tendency to adopt capitalisation for the combined risks as the system is particularly suited for invalidity.

§ 6. — Insurance Finance in the Several Countries

A. DISTRIBUTION SYSTEMS

All laws except those of Great Britain, the Irish Free State, and Northern Ireland.

The subjects which will be considered in turn below are the normal rate of contribution, the changes that may be made in the rate according to the degree of the risk, and the working of the reserve funds.

(1) *Normal Rate of Contribution*

From this point of view the laws which have adopted a system of distribution may be divided into two groups. The first, which is small, covers the cases where the contribution is fixed uniformly either for all the insured or for the separate categories of insured, although such categories do not constitute wage classes. The second comprises the laws under which the contribution varies with wages (or income), this being the system generally adopted.

GROUP 1

UNIFORM CONTRIBUTIONS

Switzerland (Cantons of Appenzell, Inner and Outer Rhodes; Basle Town; St Gall); France (seamen, for certain classes of the insured).

Switzerland

Canton of Appenzell, Outer Rhodes

In the Swiss Canton of Appenzell (Outer Rhodes) all compulsorily insured persons must pay a monthly contribution fixed by each insurance fund, subject to the approval of the Council of State.

Canton of Appenzell, Inner Rhodes

In the Canton of Appenzell (Inner Rhodes) all insured persons pay a monthly contribution of 1.20 francs. The monthly contribution for children insured voluntarily until they are 14 years of age is 0.60 franc.

Canton of Basle Town

The public sickness funds of the Canton of Basle Town require the insured to pay contributions fixed by order at five-yearly intervals. The amounts are the same for both sexes, but lower for children than for adults, and the cost of insurance must be reduced according as the number of children in the family increases. On 31 December 1925 the monthly contribution was fixed as follows:

		Francs
Adults		2.70
Supplement per child	{ for one child	1.35
	{ for two children	1.20
	{ for three children	1.05
	{ for each additional child	0.90

If these rates are compared with the table giving the sharing of the total contribution between the State and the insured according to the income of the latter, it will be seen that the cost of sickness insurance of a family of four, for instance, will be as follows:

ANNUAL COST OF SICKNESS INSURANCE FOR A FAMILY OF FATHER, MOTHER, AND TWO CHILDREN

Income of insured person	Contribution		
	Insured person	State	Total
Francs	Francs	Francs	Francs
4,500	31.80	63.60	95.40
5,000	63.60	31.80	95.40
6,000	95.40	—	95.40

Although the contribution payable by the insured varies with his wages or income, this is simply due to the fact that the proportion of the total contribution paid by the State is variable, while the total is fixed irrespective of income.

Canton of St. Gall

In the Canton of St. Gall the contribution is payable weekly and varies with the age of the insured as follows:

Age	Weekly contribution Francs
Up to 14	0.30
14 to 30	0.55
30 to 45	0.65
45 to 60	0.85

France

Seamen's Insurance (Certain Classes of the Insured)

The assessment of contributions adopted by the French Seamen's Provident Fund depends on the kind of trade in which the insured are engaged.

For overseas trade, the international coasting trade, and large fisheries the contributions payable by the crews and employers are in proportion to wages. The rates in question will be discussed later.

For the French coasting trade, deep sea fisheries, pilotage, local coasting trade (*bornage*) and small fisheries the insured are divided into five categories, as will be seen below, and the contributions are uniform in each category. It should be observed that these categories do not constitute wage classes.

The first category comprises captains in overseas trade, first engineers and others in a similar position, ships' surgeons and pursers.

The second category comprises captains in the coasting trade, officers in the mercantile marine, masters in the coasting trade, wireless telegraphists, second engineers and others in a similar position, health officers, doctors in large fisheries not holding health officers' diplomas, pilots, masters holding certificates for Iceland or Newfoundland, masters in the Algerian coasting trade, captains in the colonial coasting trade, masters in the small colonial coasting trade, stewards, book-keepers, and pursers' clerks.

The third category comprises masters or seamen not included in either of the previous two, if they are neither apprentices nor ship boys.

The fourth category consists of apprentices.

The fifth category consists of ship boys.

The rate of contribution for the various categories is as follows:

Category	Monthly contribution		
	Payable by insured	Payable by employer	Total
	Francs	Francs	Francs
I	10.00	35.00	45.00
II	6.00	21.00	27.00
III	1.80	8.40	10.20
IV	0.90	4.20	5.10
V	0.60	2.40	3 00

GROUP 2

CONTRIBUTION VARYING WITH WAGES

This second group, which contains most of the laws, will be subdivided as follows:

- (a) Laws under which the contribution is a specified proportion of true wages;
- (b) laws establishing wage classes;
- (c) laws permitting the insurance funds to choose either of the above systems or to introduce other methods of assessment.

(a) Contribution Fixed According to True Wages

Seven laws: Belgium (seamen), Chile, France (seamen, certain classes of the insured, miners), Greece, Italy (new Provinces), Russia.

Belgium

Seamen's Insurance

In Belgium the Seamen's Provident Fund, which covers the risks of sickness, disablement, old age, death, and the loss of property caused at sea, collects contributions from the insured and their employers in accordance with the following schedule, which gives the rate of contribution as a percentage of wages:

Category	Contribution per cent. of wages		
	Payable by insured	Payable by employer	Total
	Per cent	Per cent.	Per cent
I. Captains, mates, first engineers	4	1½	5½
II. All other seamen	3	1½	4½

Chile

In Chile insurance is compulsory for all persons of under 65 years of age who are ordinarily dependent on their earnings for their livelihood, provided that their wages do not exceed 8,000 pesos a year. The contribution for sickness, invalidity and old-age insurance is fixed per cent. of wages as follows:

Payable by			Total
Insured	Employer	State	
Per cent	Per cent	Per cent	Per cent.
2	3	1	6

Provisionally, pending the issue of definitive regulations based on experience, the total contribution is allocated as follows:

- 2 per cent. of wages to invalidity and old-age insurance,
- 4 per cent. of wages to sickness insurance, construction of hospitals, etc.

France

Seamen's Insurance (Certain Classes of the Insured)

As already explained, the method of assessment for the insurance of seamen in France depends on the kind of trade. The contribution is in proportion to wages for oversea trade, the international coasting trade and large fisheries, being fixed as follows:

	Contribution per cent. of wages		
	Payable by insured	Payable by employer	Total
	Per cent	Per cent.	Per cent
Officers, etc.	1 00	3.50	4.50
Crew	0 75	3 50	4.25

Miners' Insurance

For miners' insurance in France the contributions are fixed at three per cent. of wages with a maximum assessable wage of 12,000 francs a year. Thus there is an absolute maximum of 360 francs a year for the total contribution.

It has previously been stated that the contribution is divided equally between the insured and the employer, but only since the Act of 24 December 1923 came into force. The Act of 22 June 1894, which fixed the total contribution at three per cent of wages, required the insured to pay two per cent. and the employer one per cent.

Greece

In Greece the law lays down that the total contribution may not be less than three per cent. and not more than six per cent. of the part of wages subject to deduction, unless the undertaking agrees to pay a higher rate. No definition of the term "part of wages subject to deduction", however, is to be found in the law.

Italy (New Provinces)

In the new provinces of Italy the weekly contribution payable by the insured and the employer are fixed at four per cent of the daily wage, the maximum assessable wage being 20 lire. The contributions are divided equally between workers and employers.

Russia

In Russia, as already stated, the contributions for social insurance are composite, relating to all types of insurance, and payable by the undertaking alone. It is impossible to distinguish the sickness insurance contributions.

The first Act issued in December 1917 by the Soviet Government fixed the

insurance contribution at ten per cent of wages. In 1919 the contributions were fixed according to five risk classes, the minimum being 19 per cent. and the maximum 38 per cent of wages.

According to section 177 of the Labour Code of 1922 the funds of social insurance are derived from "a system of contributions fixed in proportion to wages". Undertakings are divided into "risk classes", and a rate is fixed for each class. The Decrees of January and February 1922 fixed the following insurance contributions according to the kind of risk:

	Per cent. of wages
Temporary incapacity and supplementary benefits	6 to 9
Disablement and death	7 to 10
Unemployment	2.5
Medical benefit	5.5 to 7
Total	21 to 28.5

In view of the financial situation of certain State undertakings it was found necessary to reduce the rates considerably for them, and for large-scale industry and transport undertakings. The total was fixed at 17½ per cent. irrespective of the kind of risk. Soon after, the rates had to be reduced for other undertakings as well. This led to the schedule published on 12 April 1923, which came into force as from 1 March 1923. It was divided into two parts, the first fixing normal rates and the second special rates for State undertakings and institutions.

	Per cent. of wages	
	Normal rates	Special rates
Temporary incapacity	6 to 8	3.9 to 4.5
Invalidity and death	3.5 to 5.5	2.5 to 3.5
Unemployment	2	2
Medical benefit	4.5 to 6.5	3 to 4.5
Total	16 to 22	12 to 16

The present rate of insurance contributions was fixed by the Decree of 17 August 1927.

Risk class	Contribution per cent. of wages to the			
	Cash benefit funds	Medical benefit funds	Workers' housing fund	Total
(a) Normal rates				
1	11.3	4.2	0.5	16.0
2	12.8	4.7	0.5	18.0
3	13.8	5.7	0.5	20.0
4	15.3	6.2	0.5	22.0
(b) Special rates (State undertakings and institutions)				
1	6.3	3.2	0.5	10.0
2	7.3	4.2	0.5	12.0
3	7.3	2.2	0.5	10.0
4	9.8	3.7	0.5	14.0
5	3.5	1.5	—	5.0

The normal rates are supplemented by special provisions. If the management of an undertaking is particularly careful as regards industrial safety, etc., its rate of contributions may be reduced by a certain fraction (not more than 25 per cent.). In the opposite case (carelessness of the management from the point of view of health) the rate may be increased (by not more than 25 per cent.). (Instruction of the Commissariat of Labour and the Commissariat of Finance of 28 July 1923, *Voprosy Strachkovania*, 1923, No. 32; Circular of the Commissariat of Labour of 12 July 1924, *Voprosy Strachkovania*, 1924, No. 35, Circular of the Commissariat of Labour of 27 May 1924, *Izvestia Narodnovo Kommissariata Truda*, 1924, No. 22.)

(b) Contribution Fixed According to Wage Classes

Thirteen laws: Austria, Bulgaria, Czechoslovakia, Hungary, Japan, Lithuania, Norway, Poland, Portugal, Roumania (former Kingdom and Bessarabia; Ardeal; Bukovina), Serb-Croat-Slovene Kingdom

Austria

In Austria the classification of the insured according to wages is dealt with in the Act itself. There have been several changes in the number of classes from 1919 to 1925. According to the Act of 18 March 1925, there are ten wage classes, as shown in the table below.

WAGE CLASSES IN ACCORDANCE WITH THE GENERAL SYSTEM OF THE ACT OF 1888,
ESTABLISHED BY THE ACT OF 18 MARCH 1925

Wage class	Daily wage (in schillings)	Average daily wage (in schillings)
1	up to 0.77	0.72
2	0.77 to 1.03	0.90
3	1.03 to 1.13	1.08
4	1.13 to 1.39	1.26
5	1.39 to 1.73	1.56
6	1.73 to 1.87	1.80
7	1.87 to 2.40	2.10
8	2.40 to 3.00	2.70
9	3.00 to 4.20	3.60
10	over 4.20	4.80

The total weekly insurance contribution (except for the special contributions provided for in section 9(b)) is as a rule one-half the average daily wage of the wage class (section 25, subsection 4). The normal sickness insurance contribution is given below.

Wage class	Weekly contribution (schillings)	Monthly contribution (schillings)
1	0.36	1.56
2	0.45	1.95
3	0.54	2.34
4	0.63	2.73
5	0.78	3.39
6	0.90	3.90
7	1.05	4.56
8	1.35	5.85
9	1.80	7.80
10	2.10	9.09

It may be remembered that two-thirds of the total contribution are payable by the insured and one-third by the employer.

The following table gives the distribution of the insured in wage classes from 1919. It brings out the effects of inflation during the years immediately following the war.

PERCENTAGE DISTRIBUTION OF THE INSURED BY WAGE CLASSES, 1919-1929

Wage class	1919	1920	1922	1923	1924	1925
1	7.2	$\left\{ \begin{array}{l} 2.7 \\ 0.7 \\ 2.1 \\ 1.3 \end{array} \right.$	$\left\{ \begin{array}{l} 0.4 \\ 0.3 \\ 0.2 \\ 0.1 \end{array} \right.$	3	$\left\{ \begin{array}{l} 8.4 \\ 11.1 \\ 1.5 \\ 2.4 \end{array} \right.$	$\left\{ \begin{array}{l} 0.8 \\ 0.9 \\ 1 \\ 0.9 \end{array} \right.$
2						
3						
4						
5	2.8	1.3	0.1	0.3	1.8	0.9
6	2.3	1.4	0.1		1.2	0.9
7	1.5	1.3	7	0.1	3.4	3.9
8	2.1	1.2	4.4	0.3	3.9	8
9	2.5	1.5	1.8	1.3	66.3	16.4
10	2.7	2.1	3.5	7.7	—	65.8
11	2.5	2.2	2.5	7.6	—	—
12	4.2	2	1.6	1.3	—	—
13	8.8	2.9	2.3	1	—	—
14	5.8	3.8	1.7	2	—	—
15	7.1	4.7	74.1	1.7	—	—
16	50.5	70.1	—	1.6	—	—
17	—	—	—	72.1	—	—

The table shows that four-fifths of the insured are in the two highest wage classes. As already pointed out, this concentration indicates that a considerable proportion of the wages of the insured is not covered by insurance nor liable to assessment.

Bulgaria

In Bulgaria wage-earners and salaried employees are divided by the Act into five wage classes, the rate of contribution being the same for all the members in any one class. The classification into wage classes and the corresponding contributions are shown in the table below:

Wage class	Weekly wage	Worker's contribution	Employer's contribution
1	Levas up to 15	Levas 1.50	Levas 1.50
2	16 to 30	2	2
3	31 to 45	2.50	2.50
4	46 to 60	3	3
5	61 and over	4	4

It will be remembered that the total contribution is divided into three equal parts, payable by the worker, the employer, and the State respectively.

Czechoslovakia

In Czechoslovakia, section 12 of the Act establishes ten wage classes as follows

Wage class	Daily wage in Czechoslovak kronen		Average daily wage in Czechoslovak kronen
	Over	Up to	
1	—	6	4
2	6	10	8
3	10	14	12
4	14	18	16
5	18	22	20
6	22	25 5	24
7	25.5	28 5	27
8	28 5	31.5	30
9	31.5	34 5	33
10	34 5	—	36

The limits of the wage classes may be modified by decree on the proposal of the Central Social Insurance Institute, but on the other hand the number of wage classes may not be raised above ten.

Section 159 of the Act makes the Central Social Insurance Institution responsible for fixing the sickness insurance contribution as a definite proportion of the average daily wage, which must ordinarily not exceed five per cent. The rate of the total contribution is thus fixed uniformly for the whole country.

Hungary

In Hungary the depreciation of the currency from 1919 to 1924 led to frequent changes in the limits and averages of the wage classes. The number of wage classes, fixed at nine in 1918, was first reduced to five, then raised successively to seven, nine and thirteen. At certain times the average wage of the lowest class was less than half a gold centime, and the sickness benefit was only a fraction of that average wage. Since 1922 there have been eight wage classes, and in June 1924 the limits and averages of the classes were fixed as follows:

Class	Daily wage (paper kr)	Average daily wage	
		In paper kr.	In gold kr.
1	up to 10,000	10,000	0.56
2	10 000-20,000	15,000	0.83
3	20,000-30,000	25,000	1.39
4	30,000-40,000	35,000	1.91
5	40,000-50,000	45,000	2.50
6	50,000-60,000	55,000	3.06
7	60,000-70,000	65,000	3.61
8	over 70,000	75,000	4.17

The fact that the wage classes did not take actual wages into account is shown by the following table of the percentage distribution of the insured by wage classes from 1920-1926

Date	1	2	3	4	5	6	7	8	9
January– August 1920	6.7	6.2	6.5	6.7	7.7	14.4	51.8	—	—
January 1921– February 1922	5.9	4.2	3.1	3.0	2.4	3.5	12.3	14.7	50.9
December 1923	10.6	7.9	7.6	8.4	7.1	7.1	7.2	44.1	—
March 1924	9.7	7.1	7.9	8.4	8.0	8.4	8.6	41.9	—
June 1924	10.1	7.8	8.6	10.0	9.8	10.0	9.5	34.2	—
September 1924	11.1	9.7	12.0	14.6	11.3	9.8	7.8	23.7	—
December 1924	12.7	9.7	11.9	15.4	13.0	10.2	7.3	19.8	—

In 1916 the highest wage class included only 4.7 per cent. of the insured, in 1917 11.1 per cent., in 1918 21.5 per cent., in 1920 to 1922 it had more than one-half, and in 1923 and 1924 more than one-third of all the insured. The distribution of the insured by wage classes did not become normal again until the end of 1924, but the highest wage class still includes almost one-fifth of all the insured.

The rate of contribution is fixed once a year by the National Fund. According to section 25 of the Act of 1907, the daily contribution must not be less than two per cent. or more than four per cent. of the average daily wage. At first the contribution was fixed at three per cent., but was raised from 1 December 1919 to six per cent. by Order No. 5,400 of 1919.

It will be remembered that the contribution is divided equally between the insured and the employer.

Japan

In Japan the law establishes 16 wage classes.

Wage class	Daily wage	Basic daily wage
	Yen	Yen
1	up to 0.35	0.30
2	0.35 „ 0.45	0.40
3	0.45 „ 0.55	0.50
4	0.55 „ 0.65	0.60
5	0.65 „ 0.75	0.70
6	0.75 „ 0.85	0.80
7	0.85 „ 1.15	1.00
8	1.15 „ 1.45	1.30
9	1.45 „ 1.75	1.60
10	1.75 „ 2.05	1.90
11	2.05 „ 2.35	2.20
12	2.35 „ 2.65	2.50
13	2.65 „ 2.95	2.80
14	2.95 „ 3.25	3.10
15	3.25 „ 3.75	3.50
16	over 3.75	4.00

The rate of contribution is fixed by each insurance institution. The insured person's share may not exceed three per cent. of the true daily wage. If the ratio of the contribution to the basic wage is raised so much that some insured persons are assessed at more than three per cent. of their true wage, the surplus must be paid by the employer.

Lithuania

In Lithuania the Act establishes six wage classes

Wage class	Daily wage	Weekly wage	Monthly wage	Basic daily wage
	Litas	Litas	Litas	Litas
1	Up to 4	Up to 24	Up to 100	3
2	4 „ 6	24 „ 36	100 „ 150	5
3	6 „ 8	36 „ 48	150 „ 200	7
4	8 „ 10	48 „ 60	200 „ 250	9
5	10 „ 12	60 „ 72	250 „ 300	11
6	12 „ 16	72 „ 96	300 „ 400	14

The total contribution, which is divided equally between the worker, the employer, and the State, is fixed by each fund at a certain percentage of the basic wage in such a way that the worker's contribution does not exceed three per cent. of his true wages.

Norway

In Norway all the members of the district sickness funds are classified in their proper income class in accordance with the statements and information supplied. The Act of 6 August 1915 (section 14) established the five following income classes:

Income class	Annual income Kr.	Income class	Annual income Kr.
1	Up to 300	4	900 to 1,000
2	300 „ 600	5	1,200 and over
3	600 „ 900		

The Act of 23 July 1918 introduced the six following income classes:

Income class	Annual income Kr.	Income class	Annual income Kr.
1	Up to 600	4	1,200 to 1,600
2	600 „ 900	5	1,600 to 2,000
3	900 „ 1,200	6	2,000 and over

By the Act of 17 July 1925 the number of income classes was raised to seven, as follows:

Income class	Annual income Kr.	Income class	Annual income Kr.
0	Up to 100	4	1,200 to 1,600
1	100 „ 600	5	1,600 to 2,000
2	600 „ 900	6	2,000 and over
3	900 „ 1,200		

The 1915 Act introduced the system of fixing contributions according to the income class. The rate is determined by each fund, but the Act prescribes "a normal rate" to which the funds must keep as closely as possible, or which is enforced in the absence of a special rate for the fund.

If the rate established by the fund exceeds the normal rate by more than 50 per cent., the surplus contribution must be borne by the insured person

alone, unless a decision to the contrary is taken by the competent ministry (section 31, subsection 5, para. 2, of the 1925 Act).

The normal rate is as follows:

Income class	Weekly contribution payable by compulsorily insured persons
1	25
2	35
3	45
4	55
5	65
6	70

As the contribution payable by compulsorily insured persons forms six-tenths of the total contribution, the latter is as follows:

Income class	Total weekly contribution
1	41 $\frac{2}{3}$
2	58 $\frac{1}{3}$
3	75
4	91 $\frac{2}{3}$
5	108 $\frac{1}{3}$
6	116 $\frac{2}{3}$

The number of the insured during the year in the various income classes and their percentage distribution for the years 1919-1924 are given in the table below:

Year	Income class (Kroner)					
	1 Up to 600	2 600-900	3 900-1,200	4 1,200-1,600	5 1,600-2,000	6 Over 2,000
1919 No.	46,462	75,122	84,374	64,194	55,787	217,185
Per cent.	8.54	13.83	15.54	11.82	10.27	40.00
1920 No.	40,143	63,279	76,085	65,347	50,771	263,036
Per cent.	7.18	11.33	13.62	11.70	9.09	47.08
1921 No.	36,138	56,976	67,969	62,771	48,835	275,561
Per cent.	6.59	10.39	12.40	11.45	8.91	50.26
1922 No.	36,965	56,840	70,769	66,921	50,747	288,282
Per cent.	6.48	9.96	12.40	11.73	8.90	50.53
1923 No.	39,359	57,620	73,193	69,251	51,881	288,010
Per cent.	6.79	9.95	12.63	11.95	8.96	49.72
1924 No.	42,649	58,383	75,636	71,978	51,495	284,659
Per cent.	7.29	9.98	12.93	12.31	8.81	48.68

It will be seen that the number of persons in class No. 6 rose considerably during the period in question, both in absolute and relative figures. This fact is due to the progressive rise in wages, which had all the more effect because since 1917 there has been no maximum wage for the definition of the scope of workers' insurance.

Poland

In Poland the wage classes are normally determined by the law, but may be amended by the rules of the funds. The distribution defined in the law itself includes 14 wage classes. Some funds have raised the number to 25 or even 29.

The 14 classes established by the Decree of 30 June 1924 cover wages up to 12.50 zloty a day, 75 zloty a week, and 321.50 zloty a month. These limits may be modified by the funds with the consent of the Insurance Office. Several funds have adopted a maximum of 16.67 or 19.20 zloty a day. The basic wage, except in the lowest and the highest classes, is the median wage in each class.

WAGE CLASSES AND AVERAGE WAGES ESTABLISHED BY THE DECREE
OF 30 JUNE 1924

Wage class	Daily wage	Weekly wage	Monthly wage	Average daily wage
	Zloty	Zloty	Zloty	Zloty
1	Up to 1.00	Up to 6.00	Up to 25.00	0.75
2	1.00 „ 1.50	6.00 „ 9.00	25.00 „ 37.50	1.25
3	1.50 „ 2.00	9.00 „ 12.00	37.50 „ 50.00	1.75
4	2.00 „ 2.50	12.00 „ 15.00	50.00 „ 62.50	2.25
5	2.50 „ 3.00	15.00 „ 18.00	62.50 „ 75.00	2.75
6	3.00 „ 4.00	18.00 „ 24.00	75.00 „ 100	3.50
7	4.00 „ 5.00	24.00 „ 30.00	100 „ 125	4.50
8	5.00 „ 6.00	30.00 „ 36.00	125 „ 150	5.50
9	6.00 „ 7.00	36.00 „ 42.00	150 „ 175	6.50
10	7.00 „ 8.00	42.00 „ 48.00	175 „ 200	7.50
11	8.00 „ 9.00	48.00 „ 54.00	200 „ 225	8.50
12	9.00 „ 10.50	54.00 „ 63.00	225 „ 262.50	9.75
13	10.50 „ 12.50	63.00 „ 75.00	262.50 „ 312.50	11.50
14	Over 12.50	Over 75.00	Over 312.50	12.50

If the fund cannot determine the earnings of the insured person, it takes as a basis the wages prevailing in the district for the occupation of the insured. This applies also to the classification of home workers and temporary workers.

By section 46, subsection 2, of the Decree, the contribution at the time the fund starts operations is fixed at 6.5 per cent. of the basic wage. As it is payable, however, for seven days a week, the actual proportion is 7.6 per cent. of the basic wage. These provisions apply to all funds, except those in Silesia, subject to the condition that in former Russian territory agricultural wage-earners are not liable to insurance, and that in former Austrian territory agricultural workers employed on farms of less than 75 hectares are not liable to insurance. By way of example it may be mentioned that 59 Galician undertakings, whose total wage bill in 1924 was 46,357,583 zloty, paid 3,141,885 zloty in sickness insurance contributions, or 6.8 per cent. of the total wage bill.

The average contribution for the whole country may be estimated at 7.5 per cent. of wages, of which 4.5 per cent. is met by the employers and 3 per cent. by the workers.

In Upper Silesia the sickness funds are worked in accordance with the German law. The contribution varies between 3½ per cent. and 10 per cent. of wages. At the end of 1925 the total sickness contribution was 10 per cent. of wages in one fund, from 7 to 7½ per cent. in five funds, 6 per cent. in 21 funds, and 3½ to 5½ per cent. in 20 funds.

The report *The Cost of Social Insurance in Poland and Abroad*, published by the Ministry of Labour and Social Assistance (p. 13), gives the following information on the average sickness contribution paid in the various parts of Polish territory and in different occupations.

AVERAGE SICKNESS INSURANCE CONTRIBUTION PER CENT. OF WAGES,
1924-1925

Occupation	Former Prussian territory	Upper Silesia	Former Austrian territory	Former Russian territory
Industry	7.5	6	7.5	7.5
Trade and handicrafts	7.5	6	7.5	7.5
Agriculture.				
Farms of over 75 hectares	7.5	6	7.5	0
Farms of 30 to 75 hectares	7.5	6	0	0
Farms of under 30 hectares	7.5	6	0	0

Portugal

For Portugal a preliminary observation is called for. At present the financial system may apparently be regarded as one of distribution by costs which is ultimately to be transformed into one of capitalisation. In fact, the introduction to the Legislative Decree No. 5636 of 10 May 1919 gives in outline (p. 5 of the brochure *Seguros Sociais Obrigatorios*, Lisbon, 1924) the expected results of one year's working of insurance, and points out that the estimated surplus of revenue over expenditure is sufficient to guarantee financial equilibrium. But section 35 of the Decree (p. 18) lays down that the present rate is to remain in force only as long as the Social Insurance Institute has not drawn up another "compatible with the estimates of morbidity and mortality", which certainly seems to suggest a capitalisation system. This impression is confirmed by sections 40, 46, and 47, which provide for periodical revision of the rates on the basis of mortality and morbidity tables, and for the establishment of actuarial balance sheets by which "the present values for the calculations" may be determined. On the other hand the Decree gives no indication of the bases for the capitalisation system which is apparently to be applied later, so that no more detail can be given of the nature of the financial system.

According to section 6 of the Decree, actually insured persons are divided into three income classes, but the Decree gives no definition of the classes. Section 35 lays down the following rates of contributions for actually insured persons:

Income class	Monthly contribution Escudo
1	0.50
2	0.40
3	0.30

The so-called "born insured" pay contributions varying with income as follows:

Income Escudos	Monthly contribution Escudos
900 to 1,850	0.50
1,850 to 3,800	1.00
3,800 to 5,000	2.00
Over 5,000	3.00

Roumania

In Roumania a distinction has been made between the systems in force in the former Kingdom and Bessarabia, Ardeal and Bukovina.

In the former Kingdom and Bessarabia, where the whole contribution is paid by the insured, insured persons are placed in five wage classes, the corresponding rate of contribution being indicated below:

Class	Average daily wage	Weekly contribution
	Lei	Lei
1	4.50	1.00
2	15.00	3.00
3	30.00	5.00
4	45.00	7.00
5	60.00	10.00

Assuming that there are six wage-days a week, the proportion of the contribution to the average wage thus varies, in the main falling degressively, as below:

Wage class	Contribution per cent. of wages
1	3.66
2	3.33
3	2.77
4	2.59
5	2.77

In Ardeal, where the contribution is shared equally by the insured and the employer, the insured are divided into ten wage classes.

Wage class	Average daily wage Lei	Weekly contribution Lei
1	Up to 2	0.56
2	2 to 4	1.12
3	4 to 8	2.24
4	8 to 12	3.36
5	12 to 16	4.48
6	16 to 20	5.60
7	20 to 24	6.22
8	24 to 30	8.40
9	30 to 36	10.08
10	36 to 44	12.72

The contribution represents 4½ per cent. of the average weekly wage, except in the seventh class, where it is 4.32 per cent., and in the tenth, where it is 4.82 per cent.

In Bukovina, too, the insured are classified by wages into several wage classes, but whereas in the other two parts of Roumanian territory the limits of the classes are fixed uniformly for all funds, in Bukovina these limits vary from one fund to another.

In principle the total contribution is fixed at 6.6 per cent. of the average wage in the class. One-thirds of the total contribution is payable by the employer.

Serb-Croat-Slovene Kingdom

In the Serb-Croat-Slovene Kingdom the wage classes are defined by the Ministry of Social Policy on the recommendation of the Central Workers' Insurance Institution. They must be such that the maximum basic wage corresponds to twice the average basic wage for all the insured (section 21,

subsection 2)¹. The lower limit of each class is regarded as the basic wage (improperly called the average wage). In 1924 there were 17 wage classes. The distribution of the insured in that year is given in the table below :

PERCENTAGE DISTRIBUTION OF THE INSURED BY WAGE CLASSES IN 1924

Wage class	Percentage of all insured		
	Men	Women	Total insured in class
1	6.61	1.17	7.78
2	0.24	0.05	0.29
3	0.26	0.06	0.32
4	0.76	0.16	0.92
5	4.71	0.28	4.99
6	1.83	0.41	2.24
7	1.22	0.56	1.78
8	0.78	0.54	1.32
9	1.66	1.22	2.88
10	2.64	2.95	5.59
11	3.07	2.30	5.37
12	5.95	3.20	9.15
13	5.24	1.90	7.14
14	7.50	1.81	9.31
15	9.24	1.37	10.61
16	9.36	0.82	10.18
17	18.59	1.54	20.13
Total	79.66	20.34	100.00

From 1 July 1926 the insured were divided into 18 classes, as follows:

Wage class	Actual daily wage	Actual weekly wage	Basic wage	Total daily contribution
	Dinars	Dinars	Dinars	Dinars
1	Up to 2.50	Up to 15	2.00	0.12
2	2.51 to 3.00	15.01 to 18.00	2.50	0.15
3	3.01 to 3.60	18.01 to 21.60	3.00	0.18
4	3.61 to 4.40	21.61 to 26.40	3.60	0.22
5	4.41 to 5.40	26.41 to 32.40	4.40	0.27
6	5.41 to 6.60	32.41 to 39.60	5.40	0.30
7	6.61 to 8.00	39.61 to 48.00	6.60	0.40
8	8.01 to 9.60	48.01 to 57.60	8.00	0.48
9	9.61 to 11.60	57.61 to 69.60	9.60	0.58
10	11.60 to 14.00	69.61 to 84.00	11.60	0.70
11	14.01 to 16.80	84.01 to 100.80	14.00	0.84
12	16.81 to 20.00	100.81 to 120.00	16.80	1.01
13	20.01 to 24.00	120.01 to 144.00	20.00	1.20
14	24.01 to 28.80	144.01 to 172.80	24.00	1.44
15	28.81 to 34.00	172.81 to 204.00	28.80	1.73
16	34.01 to 40.00	204.01 to 240.00	34.00	2.04
17	40.01 to 48.00	240.01 to 288.00	40.00	2.40
18	Over 48.00	Over 288.00	48.00	2.88

Thus at present the insurance contribution is fixed at 6 per cent of the basic wage.

¹ The Central Workers' Insurance Institution may, however, fix the wage class in advance for certain districts for groups of workers whose earnings are not too different, provided that the approval of the Minister of Social Policy has been obtained and the representatives of the insured and the employers have been consulted.

(c) Laws Permitting Various Methods of Assessment

Five laws Esthonia, France (Alsace-Lorraine), Germany, Latvia, Luxemburg

Esthonia

According to the law in force in Esthonia the contribution varies with the actual wages of the insured person. The amount of the contribution is fixed by the general meeting of the fund (section 321). An exception to this system is however allowed. According to section 322, the rules of the fund may provide that the rate of contribution shall be fixed according to categories instead of calculated as a percentage of each member's wages. The management of the sickness fund then lays down, subject to the provisions of the rules, the method of classifying the members and of transferring them to another class when their wages are changed.

It will be remembered that the contribution is shared equally between the insured and the employer. The rate of the worker's contribution is fixed by the general meeting of the fund and may be from one to two per cent. of their wages. It may be increased up to 3 per cent. for funds with a membership of less than 400.

France (Alsace-Lorraine)

In France (Alsace-Lorraine) in accordance with the German Code of 1911, which has been maintained in force in the departments of the Bas Rhin, Haut Rhin, and Moselle, the basic wage is fixed by the rules of each fund. It may be determined in one of four different ways.

(a) It may be made equal to the average daily wage of the class of insured person for whom the fund is set up, subject to a maximum of 5 marks. This limit was raised to 8 marks or 10 francs by the Order of the Federal Council of 22 November 1917, to 16 francs by the Decree of 28 October 1920 and to 20 francs by the Decree of 21 December 1925.

(b) It may be fixed for each of several wage classes at a certain figure as defined by the rules, either contained in the class or coinciding with the upper or lower limit. Where this method is used, the maximum basic wage that may be taken into account was originally 6 marks, which was raised to 10 marks or 12.50 francs by the Order of 22 November 1917, to 20 francs by the Decree of 28 October 1920 and to 25 francs by the Decree of 21 December 1925.

(c) The rules may take the actual wage of the insured as the basic wage up to the maximum given above, now 25 francs.

(d) Finally, for agricultural workers and temporary workers liable to insurance, the rules may take the local wage as a basic wage. This wage is fixed by the Superior Insurance Office separately for men and women, for insured persons of under 16 years of age, those of 16-21 years, and those of over 21 years.

The table below, in which methods (a) and (b) have been amalgamated, shows the extent to which the funds use each of these systems. Some employ several methods concurrently, which is the reason why the total of the three columns exceeds the number of funds in each year.

Year	Number of funds	Number of funds calculating basic wage on.		
		Average wage	Actual wage	Local wage in certain cases
1919	261	122	137	31
1920	257	128	125	38
1921	252	131	121	36
1922	247	133	114	37
1923	247	129	119	35

The funds which adopted the distribution of the insured into wage classes usually used the following system, advocated by the Federation of the Local Funds of Alsace and Lorraine ¹

Wage class	Weekly wage	Basic wage	
		Weekly	Daily
	Francs	Francs	Francs
1	0 - 24	24	4
2	24 - 36	36	6
3	36 - 48	48	8
4	48 - 60	60	10
5	60 - 72	72	12
6	72 - 84	84	14
7	84 - 96	96	16
8	96 - 108	108	18
9	over 108	120	20

The total contribution is given as a percentage of the basic wage. When the fund is started, the contribution may not be more than $4\frac{1}{2}$ per cent. of the basic wage, unless this is necessary to cover normal benefits (section 386). Subsequently, if the fund is one for an undertaking or a guild, the contributions may be increased only to cover normal benefits or by a decision taken by common agreement between the employers and the insured persons, provided that the rate does not exceed six per cent. of the basic wage. For local funds the contribution may be raised under the same conditions, but the law fixes no maximum (sections 386, 388, 389, 390).

The following table shows the rates charged by the Alsace-Lorraine funds:

DISTRIBUTION OF FUNDS BY RATE OF CONTRIBUTION

Year	Total number of funds	Contribution per cent. of basic wage					
		1-3	3-5 to 2	5-6	6-7	7-8	8-9
1919	264	2	5	64	57	121	10
1920	257	0	6	64	59	108	16
1921	252	1	2	63	67	109	10
1922	247	1	1	59	61	116	9
1923	247	0	2	48	63	123	11

Germany

In Germany, according to section 180 of the Social Insurance Code, the sickness insurance funds may fix the basic wage in one of three different ways:

- (1) according to the actual earnings of each insured person.
- (2) according to wage classes prescribed by the rules of the fund. The basic wage is then the median wage of each class. Small deviations are allowed in order to facilitate calculation. The wage classes and the basic wage must be submitted to the Superior Insurance Office for approval.
- (3) according to categories of insured persons. The basic wage is taken from the wage fixed by a collective agreement, if there exists one covering the person concerned, but, if not, it is taken to be the average daily wage of the category to which he belongs. The basic wage thus fixed must be submitted to the Superior Insurance Office for approval.

¹ *Les Assurances sociales en Alsace et Lorraine*. Exposition du Centenaire de Pasteur, Strasbourg, 1923.

The rules of a fund may provide for the parallel use of these different ways in order to meet the varied requirements of its members. The managing committee has power to order that the basic wage be fixed according to wage classes for certain groups, and according to categories of insured persons for other groups, while for certain undertakings the actual earnings may be taken as the basic wage.

By all three methods it is the average remuneration per day, working or not, which affords the basis. The average daily remuneration, however, must not exceed ten marks: the excess is disregarded. For the calculation of average daily earnings, the week is taken to be seven days and the month to be 30 days, and the year to be 360 days.

The rate of contribution is expressed as a percentage of the basic wage and fixed by the responsible organs of the various funds in such a way that the contributions together with other income are sufficient to meet the ordinary obligations of the fund (section 385).

The contribution may not be increased above 7.5 per cent of the basic wage unless this is necessary to cover ordinary benefits, and then only if half the employers and insured on the managing committee agree. If a contribution of 10 per cent. of the basic wage is not enough to pay for the ordinary benefits, it may not be raised otherwise than by common agreement between the employers and the insured on the managing committee.

The percentage distribution of the funds in 1924 according to the rate of contribution, given in the following table, is taken from the *Statistik des Deutschen Reichs*, Vol. 338:

Contribution per cent. of wages	Number of funds per cent. of total		
	1914	1924	1925
2	5.7	0.2	0.1
2 to 3	42.1	2.8	2.0
3 to 4	36.9	8.7	7.9
4 to 4½	13.6	11.1	10.0
4½ to 6	1.7	60.7	63.0
6 to 7½	—	13.2	14.6
7½ to 10	—	3.3	2.4
	100	100	100

DISTRIBUTION OF INSURED ACCORDING TO PROPORTION OF CONTRIBUTION TO WAGES IN 1925

Type of fund	Per cent. of insured paying contribution of						
	under 2 %	2-3 %	3-4 %	4-4½ %	4½-6 %	6-7½ %	7½-10 %
	of the basic wage						
Local funds	—	—	1.6	2.7	63.4	29.7	2.6
Rural funds	—	0.6	6.3	6.1	57.2	22.5	7.3
Works funds	—	1.0	3.1	7.9	52.7	26.6	8.7
Guild funds	—	0.9	9.7	4.7	76.6	7.0	1.1
All funds	—	0.3	2.6	4.1	61.0	27.8	4.2

Latvia

In principle the Latvian law adopts the system of contributions varying with individual wages. By the rules of the sickness fund, however, the contribution, instead of being fixed as a percentage of the wage of each member, may be determined according to wage class. The members of the fund are

then classified according to the information on their wages supplied by the employer to the management of the fund. Regulations concerning the classification of the members, and their transference from one class to another in the event of changes in their wages, are adopted by the management of the fund in accordance with the provisions of its rules (section 61).

It will be remembered that the total contribution is divided equally between the insured, the employer, and the State.

The rate of contribution payable by the members of the fund is fixed by the general meeting at not less than one per cent and not more than two per cent. of the wage. Sickness funds with a membership of under 400 may raise the rate of their contribution to not more than three per cent. of wages. The employer, moreover, is liable for the cost of medical aid, and, where this is provided by the fund, the employer must reimburse it by a contribution varying between one and two per cent. of wages.

Luxemburg

In Luxemburg the total contribution is proportionate to the insured person's wage. The wage to be taken into account is either his actual wage or his so-called normal wage. The latter is defined as the average daily wage fixed by the rules on the basis of the various wage rates of the members of the fund (section 7, amended by the Act of 31 December 1925).

If the fund bases its contribution on the normal wage, the system is in effect that of wage classes, but the law does not itself define the different wage classes, which are determined by the rules of the individual funds. The law merely establishes a maximum normal wage, fixed according to circumstances by public administrative regulations. The Grand Ducal Decree of 6 January 1926 fixed this maximum at 27 frs. a day. This same maximum also applies to funds which establish their contributions in proportion to actual wages.

The rules of each fund fix the rate of the total contribution as a percentage of the normal wage (section 70). The law merely prescribes two maxima which must not be exceeded:

- (1) When a fund is first formed, the rate of contribution must not exceed 4.5 per cent. of the normal wage.
- (2) Subsequently, an increase in that rate is allowed only if approved by the employers and insured, or if necessary to cover the normal benefits of the fund. In the latter case the increased rate may not exceed 6.75 per cent. of the normal wage (section 72).

The following table gives the rates of contribution for 1923 for local and industrial funds together:

Contribution per cent of wages	Number of funds	Number of insured per cent of total
under 4.5	22	46.38
4.5	15	30.00
over 4.5	9	23.62

(2) *Calculation of Wages: Periods of Exemption from Payment of Contribution*

Calculation of Wages

In most of the laws considered the wage includes all forms of remuneration for work done: cash wages properly so called, over-time pay, share in profits, various bonuses even if they do not arise directly out of the contract of employment, wages in kind. The Czechoslovak Act even adds any valuable considerations

received from third parties if these affect the total wage, but on the other hand, excludes casual earnings. Similarly, in Hungary the various supplements to wages are not taken into account unless they are of a permanent nature. In the Serb-Croat-Slovene Kingdom the law is more restrictive, including in wages only the remuneration due under a contract of employment. The Japanese Act excludes bonuses payable at intervals of over three months, and rent if this allowance does not affect the amount of the wage. In most countries the cash value of wages in kind is estimated by the insurance institution, subject to the check of the supervisory authorities.

Further, where the system of wage classes is in force, the limiting and basic wages in each class are expressed in relation to a certain time unit (usually a day or a week) which does not always coincide with the actual period of the wage. This makes it necessary to have definite rules relating the actual daily, weekly, monthly, or annual wages to the time unit used in the definition of the wage classes. The coefficients adopted are not the same in all laws, but it seems unnecessary to examine this detail more closely. It need merely be stated that as a rule the weekly, monthly, or annual wage is calculated from the daily wage by multiplying it by 6 (in some cases 7), a number between 24 and 30, and a number between 300 and 360 respectively.

Nor will there be any need to discuss the various regulations for converting piece wages to time wages, or the effect of fluctuations in the actual wage and the periods within which these must be followed by a transference to another wage class.

Periods of Exemption from Payment of Contributions

A rule that is almost universally applied is that contributions need not be paid during an illness involving loss of working capacity. In theory this necessitates a correction in the calculation of the contributions; in other words, the daily sickness benefit must be considered as consisting of the actual benefit plus the daily amount of the contribution. Similarly, a number of laws (see the Chapter on benefits) allow persons involuntarily unemployed to retain the right to benefit without requiring them to pay contributions.

In the systems where the contribution is fixed in proportion to wages this rule follows directly from the process of assessment; as the incapacity to work usually involves a suspension of wages, the subject of assessment itself disappears. Moreover, this makes

it possible for an employer not to pay a contribution in respect of a worker whom he has temporarily dismissed and therefore ceased to pay.

This argument does not apply if the contribution bears no relation to wages and if no share in the cost is borne by the employer. Thus in the Canton of Appenzell, Inner Rhodes, the contribution is payable even during sickness.

(3) *Variation of Contribution According to Degree of Risk*

The provisions of the laws enabling the rate of contribution to be varied according to the degree of risk are reproduced below, several cases being distinguished according as the increased risk is due to the kind of occupation or undertaking, to physiological conditions (age, sex), or, independently of the frequency of the event insured against, to the higher cost of insurance resulting from the provision of benefits for dependants or for persons in areas of sparse population or bad communications.

INCREASED RISK RESULTING FROM THE KIND OF OCCUPATION OR THE NATURE OF THE UNDERTAKING

In *Austria* the rules of the funds may graduate the contributions for different classes of members if experience has shown important variations in the degree of risk, and such graduation may in particular be effected according to the kind of occupation or the nature of the undertaking. Moreover, the contributions in respect of persons employed in an undertaking, the equipment of which does not comply with public health regulations, may be increased by as much as 50 per cent. of the normal contribution, the addition being paid solely by the employer.

In *Czechoslovakia*, the rate of contribution is fixed in accordance with wages by the Act, without regard to the degree of risk, but at the request of a sickness insurance institution the central institution may, after consulting the labour inspector and the administrative authority of first instance, impose an additional contribution on undertakings where less than ten persons are insured, and where the equipment is not in accordance with public health and preventive regulations.

In *Estonia*, the general meeting of members of a sickness fund may take into consideration the degree of risk of an undertaking in fixing the rate of workers' and employers' contributions.

In *France (Alsace-Lorraine)*, the legal provisions are the same as in Germany. In seamen's insurance, the rates are fixed without regard to the degree of risk.

In *Germany*, the rules of a fund may provide for contribution rates varying according to the industry or the occupation of the insured person (section 384 (1)). The rules may increase the employers' contribution for certain industries when the risk of sickness is markedly high (section 384 (1)).

In *Hungary*, an employer who does not take the preventive measures prescribed by the authorities is required to pay an additional contribution which may be as much as half the normal contribution.

In *Japan*, the rate is as a rule uniform, but it may be raised in the case of persons engaged in dangerous occupations.

In *Lithuania*, the committee of the sickness fund may, with the approval of the Superior Insurance Office, increase the rate of the employers' contributions in the case of undertakings where the risk is especially high.

In *Luxemburg*, the rules of the funds may graduate the rates of contributions according to the industry or the occupation of the insured person. They may provide for an increased employers' contribution where the undertaking exhibits a particularly high degree of risk.

In *Norway*, the law had at first provided for four risk classes, but this system was abolished by the Act of 6 August 1915, which reduced the number of classes to two. As a matter of fact, however, all insured persons are, in accordance with the policy of the Ministry of Social Affairs, placed in a single risk class.

In *Poland*, with the consent of the Insurance Office, a fund may increase the employers' contributions in undertakings where a higher degree of risk has been observed, or simply in view of the character of the undertakings, or again because raw materials declared to be harmful by the Ministry of Public Health are utilised in the undertaking.

In the *Serb-Croat-Slovene Kingdom* the rate of contribution is likewise uniform in principle. Nevertheless, undertakings which are especially dangerous must pay an additional premium, but have the right to appeal to the Central Workers' Insurance Institution.

In *Russia*, as has been stated already, the rates of contribution are based on risk classes.

INCREASE OF RISK DUE TO PHYSIOLOGICAL CAUSES

As a general rule no account is taken, in drawing up the scale of contributions, of the age or sex of insured persons, or of their state of health (liability to diseases, etc.). The only mode of selection which operates is that which results from the fact that a person cannot be sick at the very moment when he becomes insured.

Nevertheless in *Austria*, the rules of the funds may, as has already been stated, vary the contributions for different classes of members, and these classes may in particular be based on the sex of insured persons. It is however recommended that higher rates of contribution should not be fixed for women save in exceptional circumstances, for example in funds where women form more than one-third of the total of the membership.

It may be noted, further that in *Switzerland*, in the Canton of St. Gall, the rate of contribution varies for different age groups (below 14, 14 to 30, 30 to 45, 45 to 60), and takes into account to a certain extent the increased morbidity rate corresponding to advancing years. In the Canton of Basle Town, the Act prescribes that the contributions are to be the same for both sexes, but should be higher for adults than for children. There exists nowhere, it would seem, a special rate of contribution for voluntarily insured persons: the latter pay on the same scale as the compulsorily insured. At the same time in *Austria*, the provision that contributions may be graduated in accordance with age applies only to voluntarily insured persons. Apart from this case, there is no variation for individuals of the contribution in proportion to the physiological risk, either for voluntarily or compulsorily insured persons. Here a real danger presents itself for the financial stability of insurance funds for, in spite of the selection which the latter are allowed to exercise among candidates for admission, it is to be expected that the average morbidity of voluntarily insured persons will be ordinarily higher than that of compulsorily insured persons.

INCREASED COST OF INSURANCE RESULTING FROM FAMILY BENEFITS

In *Chile*, insured persons who wish to have medical benefit provided for their family must pay an additional contribution amounting to 5 per cent. of their wages or income.

In *France (Alsace-Lorraine)*, the right to benefits for dependants may necessitate an additional contribution in respect of the insured persons concerned.

In *Germany*, funds which have introduced family insurance may require from insured persons having a dependent family an additional contribution. Nevertheless, no increase may be imposed in respect of maternity benefits

granted to members of insured persons' families, since these benefits are not additional, but prescribed by law.

In *Lucemburg*, funds which grant benefits to the wives of insured persons may require from married insured persons an additional contribution, the rate of which must be fixed in a uniform manner by the rules. On the other hand when the rules grant to certain insured persons only partial benefits (either medical benefit only, or cash benefit only), the contributions of such persons are to be proportionally reduced.

INCREASED COST OF INSURANCE IN SPARSELY POPULATED AREAS

In *Chile* the insured person's and the employer's shares of the contribution are increased by 1 per cent. of wages, and likewise the State subsidy, in the provinces of Carapacá, Antofagasta, and the Magellan Territory. The total increase of 3 per cent. of wages serves to cover the extra cost of providing benefits in areas where communication is particularly difficult and where the population is very scattered.

(4) *Reserve Funds*

The principal legislative regulations concerning reserve funds in sickness insurance funds working on the system of distribution of costs are summarised below for the separate countries in turn, statistics showing the amounts of these funds for all insurance institutions combined being given in each case. As the financial system of the Russian Soviet Union is quite distinct, as full a description as possible has been given of the formation and aims of the various social insurance funds in that country.

Austria

The amount of the reserve fund must be not less than the average expenditure during the last three years. If necessary, the fund may be increased again up to this minimum (section 28). The resources of the fund are derived from a certain proportion of contributions and various fines.

In addition to the reserve fund prescribed by the law, special funds may be formed connected with sickness insurance. In particular these funds may be used to grant supplementary benefits, to provide special equipment for the care of the sick and convalescent in excess of statutory benefits, to take preventive measures against social diseases such as tuberculosis, alcoholism, and venereal disease, and to encourage the campaign against these evils. In the absence of other resources, these special funds may be created by the levy of a contribution from the insured, collected in the same way as other contributions. The collection of contributions from employers, and the increases on the general rate of contributions for this purpose, are allowed only with the agreement of the employers' representatives, voted by a simple majority at a general meeting.

Year	Total reserve funds	Reserve funds per cent. of total contributions
1919	66,881,046 paper crowns	25.7
1920	173,367,874 "	21.3
1921	1,130,427,572 "	31.3
1922	28,341,927,387 "	22.9
1923	106,656,320,874 "	17.2
1924	229,403,382,323 "	14.4
1925	30,413,432 schillings	7.7

Although from the legislative point of view the system of miners' sickness insurance is the same as the general system, the finance is separate. The following figures may be given

Year	Total reserve fund (million paper crowns)	Reserve fund per cent. of total contributions
1919	1.7	37.4
1920	3.3	22.5
1921	25	26.7
1922	1,012.1	24.4
1923	3,948.8	28.9
1924	7,312.1	36.6

Belgium (Seamen)

In connection with the working of the fund, a reserve fund is accumulated covering all the risks insured against (sickness, disablement, old age, death, shipwreck). The rules contain no information on the conditions to be fulfilled by the reserve funds.

Bulgaria

In Bulgaria the financial management of all social insurance is co-ordinated. The total revenue derived from the contributions of employers, insured, and the State, and extraordinary receipts form the Social Insurance Fund managed by the National Social Insurance Office. In addition to the three ordinary accounts, for the three branches of social insurance (accidents, sickness and maternity, invalidity, and old age), to which these moneys are allocated, there are two other accounts, one for "extraordinary receipts" and the other for "reserve". The allocation to these various accounts, including the "reserve" account, is carried out once a year by the management of the Social Insurance Fund

CAPITAL RESERVE OF THE SOCIAL INSURANCE FUND

Year	Amount	Index number 1919 = 100
	Levas	
1919	4,632,901	100
1920	5,566,528	120
1921	9,466,528	204
1922	13,166,528	284
1923	16,656,526	360
1924	16,656,526	360
1925	41,962,876	906

Czechoslovakia

Every sickness insurance institution uses its surplus revenue to create and increase a reserve fund, which must be brought up to a figure at least equal to the average expenditure for the last three years. If need be the fund must be increased again up to this amount (section 178).

Year	Total reserve funds	Allocation to reserve funds during the year	Allocation per cent. of contributions paid during year
	Crowns	Crowns	
1919			
1920	104,950,429	45,373,863	18.65
1921	244,901,740	139,194,865	18.61
1922	284,927,536	20,781,305	2.56
1923	340,627,757	55,532,732	7.47

Esthonia

The reserve fund is made up as follows

- (1) A deduction from the total contributions, the amount being determined by the rules. It may be 5 to 10 per cent. of the total.
- (2) Annual surplus revenue
- (3) The proceeds of fines imposed on members by the management of the insurance fund, and the interest payable by employers whose contributions are in arrear
- (4) Donations and legacies not devoted to a specified purpose.

The deductions cease as soon as it appears from the annual financial report of the insurance fund that the reserve has reached a sum equal to the expenditure of the fund during the last two years. As soon as the capital of the reserve fund falls below this sum, the deductions are again enforced

RESERVE FUND AT THE END OF THE YEAR IN ESTHONIAN MARKS

Year	Ordinary sickness insurance funds		Various industrial funds	
	Total	Amount per insured	Total	Amount per insured
1919	153,374.84	33.50	237,155.54	31.74
1920	693,159.75	89.30	673,489.23	101.39
1921	2,879,061.10	239.70	2,948,741.12	418.70
1922	6,256,714.56	402.50	4,487,923.95	451.50
1923	10,276,553.22	476.10	6,879,212.15	554.20
1924	16,007,844.02	709.60	7,605,844.57	691.20

France

Alsace-Lorraine

For the regulations in force see *Germany*.

RESERVE FUNDS (IN FRANCS)

Year	Total	Amount per insured	Average expenditure of last three years
1919	10,108,078	29.60	19,317,929
1920	20,047,908	52.03	24,607,865
1921	30,145,310	77.10	31,702,918
1922	36,111,052	87.35	41,422,565
1923	40,550,517	92.36	53,759,794

It will be seen that in the period covered the aggregate reserve funds of all the institutions never reached the legal minimum.

Seamen's Insurance

The reserve fund of the Provident Fund was originally constituted out of the capital accumulated during the period when the fund worked on the capitalisation system (1898 to 1905). Any excess of annual income over the sums needed for paying benefits is placed in the reserve. It is intended to cover, up to a reasonable amount, any deficits on the year's working, and to refund State advances. (See below, § 7, "Guarantees", page 510.)

AMOUNT OF THE RESERVE FUND AT THE END OF THE YEAR

Year	Francs
1913	28,089,000
1919	18,180,000
1920	18,231,000
1921	19,595,000
1922	18,130,000
1923	16,828,000
1924	14,636,000

Miners' Insurance

At the end of each year the administrative council of each benefit fund determines what sum out of the available surplus shall be left in the fund to ensure the payment of benefits. The remainder is deposited in cash in the Government Deposit Fund (*Caisse des dépôts et consignations*), which, according to section 21 of the Act of 1 April 1898 on mutual-aid societies, which applies to the miners' societies, pays interest on the moneys thus deposited, at present at the rate of $4\frac{1}{2}$ per cent.

The total of the sums retained by each society, and those placed in the deposit fund, constitutes the reserve of the benefit fund. This reserve may not exceed twice the annual receipts (section 16 of the Act of 1894).

RESERVE FUNDS OF MINERS' MUTUAL AID SOCIETIES ON 31 DECEMBER OF EACH YEAR

Year	Total reserve	Amount per insured	Part of the reserve	
			Kept by the fund or deposited in a savings bank	Deposited in the Government Deposit Fund
	Francs	Francs	Francs	Francs
1913	—	—	—	3,364,404
1919	10,198,488	5.58	—	—
1920	13,219,882	6.57	6,463,870	6,757,012
1921	14,146,614	6.31	5,462,792	8,683,822
1922	14,902,680	6.21	5,345,880	9,556,800
1923	19,601,615	7.39	6,961,478	12,640,137

Germany

Each sickness fund accumulates a reserve fund of not less than the average annual expenditure for the last three years, and keeps it at this level. It is derived from a deduction of $\frac{1}{20}$ of the annual receipts from contributions (section 364).

The maximum of the reserve fund is fixed at double the legal minimum (section 392).

The total amount and the average of the sickness fund reserves working under the Social Insurance Code were considerably less in 1924 than in 1914. This was obviously the result of the inflation of the currency, which practically wiped out the reserves of all the insurance institutions. At the end of 1914 the reserve funds amounted to 305,800,000 gold marks, at the end of 1924 to 63,100,000 gold marks, and at the end of 1925 to 104,900,000 gold marks, or only one-third of the 1914 figure.

Hungary

The constitution of a reserve fund common to all the insurance institutions is in the hands of the National Workers' Insurance Fund. The resources of the reserve fund are derived in part from the district funds, but the latter may also form their own reserves. According to section 118, subsection 1, of the 1907 Act, two-thirds of the net annual surplus of the district funds is paid into the National Fund. The district funds are free to decide what use is to be made of the remaining third, provided that it is employed only in giving more generous satisfaction to the legitimate claims of the insured for relief or in constructing and maintaining institutions for the relief of the sick. The published accounts of the funds show that in fact this part of the surplus may be placed to reserve.

Further, the National Workers' Insurance Fund is required to accumulate a reserve fund for paying sickness benefits in cases of emergency. As long as the sums in hand are not equal to the average annual amount paid in sickness benefit during the last five years, 50 per cent. of the net income of the National Fund is paid into the reserve. For the reserve to reach twice that sum a special permit of the competent Minister is necessary.

Any use made of all or part of the reserve requires the authorisation of the Minister. The sums spent must be replaced (section 30, subsections 1 to 4).

There are thus sickness insurance reserve funds in the National Workers' Fund and each sickness fund. The reserves of the National Fund and the most important district fund (that of Budapest) are shown below:

Year	National Workers' Insurance Fund	Budapest District Fund
	Crowns	Crowns
1919	16,031,586	3,636,256
1920	16,501,825	3,742,914
1921	33,835,015	4,318,215
1922	41,730,890	4,748,245
1923	180,153,660	5,107,681
1924	—	5,508,960

Japan

The sickness insurance funds may accumulate reserves with a view to meeting any expenditure in excess of the estimated amount. A sum must then be set aside out of surplus revenue equal to 5 per cent. of the average annual expenditure for the last three years, until the reserve reaches that average.

Latvia

The reserve fund is made up of (a) deductions from total contributions and subsidies, the amount of which is fixed by the rules at not more than 5 to 10 per cent of the total; (b) annual surplus revenue, (c) the proceeds from fines imposed by the management of the insurance fund and fines payable by employers for failure to pay their contributions to the insurance fund within the specified period, (d) donations and legacies not allocated to a specific purpose

The deductions referred to above cease when the annual financial report of the sickness fund shows that the amount of the reserve is equal to the expenditure of the fund for the last two years. They are resumed when the reserve falls below this sum.

Lithuania

Every sickness fund must form a capital reserve fund, the amount of which must be equal to twice the average annual expenditure for the last three years. The insurance fund must see to it that the capital thus accumulated does not fall below that level.

The resources of the reserve are derived from the following

- (1) A maximum deduction of 10 per cent from the contributions of workers, employers and the State.
- (2) Any profits on the year's working
- (3) The fines imposed by the committee of the insurance fund, the factory inspectors, or the Superior Social Insurance Office.
- (4) Grants and donations not allocated for a particular purpose

The reserve capital may be used when the working capital is not sufficient to cover the ordinary expenditure of the insurance fund

Luxemburg

All insurance funds must form a reserve fund of not less than the annual average of the expenditure for the last three years, and must keep it at this level. For this purpose they must deduct a proportion of not less than 1/20th of the annual contributions. The maximum of the reserve fund is fixed by the supervisory authorities (i.e. the Central Committee)

RESERVE FUND OF LOCAL AND INDUSTRIAL FUNDS

Year	Total	Amount per insured	Per cent. of ordinary expenditure
	Francs	Francs	
1918	1,678,472	38.62	40.54
1919	1,744,794	46.94	47.04
1920	1,796,390	47.39	45.10
1921	1,998,993	52.83	39.78
1922	2,421,865	65.30	42.35
1923	2,902,202	71.27	48.20

Norway

There are two forms of reserve fund, one constituted for all insurance funds by the State Insurance Institution, the other formed by each of the funds on their own account.

Part of the State share in contributions to the sickness fund is kept back and paid into a special fund known as the Equalisation Fund. The proportion of the contribution payable to this fund is fixed once a year by the

Government, on the recommendation of the State Insurance Institution, but must not exceed 1/10th of the State share in the contribution. When the Equalisation Fund has reached 1/5th of the expenditure for the past year, the Government may lay down that the deduction referred to above may be subtracted from the State contribution to sickness insurance.

Further, if a district insurance fund obtains a surplus on the year's working, this is paid into a reserve fund until the reserve reaches during three consecutive years an amount not less than the average six-monthly receipts from contributions during the three years, or until it is at least equal to the receipts from contributions during the past year.

EQUALISATION FUND* NON-INTEREST BEARING LOANS

Year	Equalisation Fund		Loans	
	Amount	Per member	Amount	Per member
	Kroner	Kroner	Kroner	Kroner
1918	712,938	2 11	261,990	0.78
1919	3,143,264	5 79	1,735,424	3 20
1920	4,081,509	7 31	1,910,361	3.42
1921	5,121,517	9 34	1,620,008	2 95
1922	6,082,697	10.66	1,613,302	2 83
1923	7 106,423	12.27	1,460,427	2.52
1924	8 129,234	13 90	1,025,865	1.75

RESERVE FUNDS

Year	Urban district funds	
	Amount	Per member
	Kroner	Kroner
1918		
1919	2,657,709	10.88
1920	4,080,346	16.17
1921	6,138,406	24.81
1922	5,066,372	19.34
1923	5,861,451	21.85
1924	5 958,108	22.03

Rural District Reserve Funds

Year	Amount	Per member
	Kroner	Kroner
1919	2,893,483	9 68
1920	4,410,738	14.40
1921	5,406,972	17.98
1922	5,845,265	18.94
1923	8,029,076	25.81
1924	9,529,368	30 28

Total District Reserve Funds

Year	Amount	Per member
	Kroner	Kroner
1919	5,551,192	10.22
1920	8,491,084	15.20
1921	11,545,378	21.06
1922	10,911,637	19.12
1923	13,890,527	23.98
1924	15,487,476	26.48

Whereas the reserves of the Equalisation Fund and the district funds increased almost threefold from 1919 to 1924, there was a certain fall in the amount of the non-interest bearing loans. This would seem to indicate the financial stabilisation of the district funds, which find it less and less necessary to appeal to the Equalisation Fund, as well as a balancing of the revenue and expenditure of the insurance institutions.

Poland

Each insurance fund accumulates a reserve equivalent to the average annual expenditure for the last three years, and must keep the reserve up to this minimum. Not less than 10 per cent. of the total contributions must be set aside for this purpose.

By the end of 1924 the total reserves of the sickness funds (168 funds) amounted to 23,953,967 zloty, or about 15 zloty per insured person.

According to the annual reports of the Warsaw sickness fund, the following percentage of receipts was placed in the reserve:

Year	Percentage of receipts
1920	60.86
1921	29.19
1922	28.47
1923	44.67
1924	25.64

In 1925 the sum of 1,671,403 zloty (4,803,609 zloty in 1924) was placed in the Warsaw reserve fund, representing 6.20 per cent. (25.64 per cent. in 1924) of the total receipts of the insurance fund, and 9.68 zloty (26.35 zloty in 1924) per insured person.

Portugal

The law provides for two kinds of reserves. The first of these are in some respects similar to the actuarial reserves in a system of capitalisation. For each mutual aid society they constitute a permanent inalienable fund derived from part of the interest on the fund itself as fixed by the rules, not less than 60 per cent. of the available annual balance, the balances of the accounts in the society's favour, donations and extraordinary receipts, which have not to be used as working capital under the rules, and part of the net revenue of the "economic fund" or other organ of the society as fixed by the rules.

Further, the mutual aid societies may organise special non-permanent reserve funds to meet deficits. These are constituted out of annual deductions from the working capital.

Russia

The financial working of social insurance in the Russian Soviet Union is based on a graduated system of compound funds. The aggregate resources of social insurance are used to constitute the following funds, known as "working" funds:

A — Funds directly at the disposal of the social insurance authorities, subdivided into:

- (a) funds of the insurance societies,
- (b) provincial (departmental) funds¹;
- (c) funds of the federal republics;
- (d) the Federal Fund.

B. — The medical benefit funds, which are at the disposal of the public health authorities and are divided into:

- (a) district funds²;
- (b) provincial funds³;
- (c) funds of the federal republics.

In the insurance of transport workers, there are no provincial funds or funds of the federal republics, while the district medical benefit funds are replaced by funds for the main lines and railway divisions.

This system of social insurance funds was introduced in 1924. Until then, there were four separate funds:

- Fund A: For temporary incapacity and supplementary benefits.
- Fund B: For invalidity and death.
- Fund C: For unemployment, and
- Fund D: For medical benefit.

The resources of these funds were strictly delimited under the legislation in force, but it soon became necessary to make transferences from one fund to another, and this led to the present situation. It is even likely that the medical fund will ultimately be incorporated altogether with the general fund, in view of the tendency of the trade unions to demand that the system of medical insurance should again be made independent, at least financially, of the Commissariat of Public Health.

FUNDS DIRECTLY AT THE DISPOSAL OF THE SOCIAL INSURANCE INSTITUTIONS

Funds of the Insurance Societies

The funds of the insurance societies are derived from:

- (1) the contributions of employers for all forms of insurance excluding medical benefit, and subject to the deduction of 10 per cent for the constitution of the funds for the federal republics and the Federal Fund:
- (2) fines for arrears in the above payments,
- (3) subsidies granted by the provincial (or corresponding) fund;
- (4) interest on capital and other revenue.

For the transport funds, any fines imposed for contravention of social legislation are also paid into the fund. Moreover, these funds receive subsidies direct from the Federal Fund.

In addition to the ten per cent. payment for the constitution of the Federal Fund, supplementary sums may be deducted in pursuance of an order of the Central Social Insurance Department of the Soviet Union or the principal social insurance department of the republic concerned. In the latter case the order must be confirmed by the Central Social Insurance Department. Half the additional sums thus collected are paid into the fund of the republic concerned and half into the Federal Fund.

The insurance societies (both territorial and transport) have full right to dispose of their funds. The bodies subordinate to the societies, such as local offices or representatives, are financed by their respective societies.

The funds of the insurance societies are used for paying pensions and allowances, providing all forms of relief, and finally meeting the cost of organising the society. Part of the fund may be spent on supplementary benefits and preventive measures in accordance with a budget drawn up by the principal social insurance department of the republic concerned on the lines of the

¹ In certain republics and federal provinces of the Union, provincial or regional societies take the place of the departmental societies.

² In certain republics and federal provinces, municipal funds take the place of the district funds.

³ See footnote 1.

general scheme of the Central Federal Department. The expenditure of the transport funds is directly subject to the Federal Department.

Once a year, and not later than 25 October, the insurance societies transmit to the provincial (or corresponding) fund any surplus in their hands on 1 October retaining only what is necessary for the expenditure of the month.

The resources of the insurance societies are placed in the credit institutions designated by the principal social insurance department of the republic concerned.

Provincial (or Corresponding) Funds

The provincial funds are derived from:

- (1) The surpluses of the insurance societies' funds (see above).
- (2) Fines imposed for contravention of social legislation.
- (3) Subsidies from the fund of the republic concerned and other subsidies (see below)
- (4) Interest on capital, etc.

If an insurance society has a considerable surplus, the social insurance authority immediately superior to it may transfer this sum directly to a society within its territory which has suffered a deficit, or place the surplus directly in the provincial fund. For transport societies, transferences of this kind may be effected only by the Central Social Insurance Department.

The provincial insurance authority disposes of the resources of the provincial fund, which are used to subsidise the insurance societies' funds and for purposes of organisation, including insurance propaganda. The provincial fund may also be spent on granting benefits in kind or in the form of work over and above the pensions and allowances, and in taking preventive measures of general interest to the province.

The above expenditure is effected on an annual budget except for the supplementary expenditure (supplementary relief and preventive measures), which is determined by the principal social insurance department of the republic concerned.

The resources of the provincial funds are placed in the credit institutions designated by the principal social insurance department of the republic.

Funds of the Federal Republics

The social insurance funds of the federal republics consist of:

- (1) 50 per cent. of all the payments made by the insurance societies (see above),
- (2) 50 per cent. of the supplementary payments made by the insurance societies (see above);
- (3) Subsidies from the Federal Fund and other subsidies (see below);
- (4) The balances of the insurance societies' funds and fines, and of the subsidies from the provincial funds, etc ,
- (5) Interest on capital, etc.

The sums specified under 1, 2 and 3 are paid by the insurance societies into the current account of the fund of the republic. These payments must be effected not later than the fifth of each month.

In cases of necessity, transferences from the insurance societies or provincial funds may be authorised for the benefit of the societies or provincial funds of other provinces or of the funds of the republic. This requires the authorisation of the principal social insurance department, and the approval of the social insurance council of the republic.

The credit institutions in which the social insurance funds (of the societies and provincial funds) are placed are bound to transfer direct to the fund of the republic the sums asked for by the principal department, subject to notification of the insurance societies concerned.

The fund of the republic is used to grant subsidies to the provincial funds for preventive measures of general importance to the whole republic and supplementary relief in kind or in the form of work, and to cover the expenses of organisation including insurance propaganda. This expenditure takes place in accordance with the general programme drawn up by the Federal

Social Insurance Department. The social insurance budgets of each republic are approved by the insurance council of the republic and the Central Insurance Department of the Soviet Union.

The social insurance fund of a republic may be placed in a current account in the designated credit institutions or converted into securities guaranteed by the State, in accordance with the list drawn up by the Federal Commissariat of Finance in agreement with the Federal Commissariat of Labour. Interest-bearing securities must be deposited in the credit institutions.

The Federal Fund

The Federal Social Insurance Fund is made up of:

- (1) 50 per cent. of the payments made by the insurance societies (see above);
- (2) the total payments made by the transport societies,
- (3) 50 per cent. of the supplementary payments made by the insurance societies (see above);
- (4) the sums resulting from transferences;
- (5) interest, etc.

The payments by the insurance societies must be made not later than the fifth of each month.

In case of need, direct transferences may be authorised from the insurance societies' funds, the provincial funds, and the funds of the republics to the Federal Fund. Such transferences take place in accordance with a decision of the Federal Central Department subject to the approval of the Federal Social Insurance Council. Afterwards, the principal social insurance department of the republic concerned must be notified. On the instructions of the Federal Central Department, the credit institutions in which the social insurance funds have been placed must immediately transfer the sums asked for, afterwards notifying the insurance authority concerned. The Central Social Insurance Department may use the Federal Fund to grant subsidies to the funds of the republics and the transport funds, to provide supplementary relief in kind or in the form of work over and above pensions and allowances, to take preventive measures of general importance to the whole Union, and to cover the cost of organisation including insurance propaganda.

The expenditure is in accordance with a budget which must be confirmed by the Federal Social Insurance Council. The payment of sums to the funds of the federal republics or the transport societies is determined by the Federal Social Insurance Council.

The Central Social Insurance Department draws up a scheme for the provision of supplementary relief in kind or in the form of work, applied to all the federal republics and the transport societies. This scheme is confirmed by the Federal Social Insurance Council.

The resources of the Federal Fund may be placed in a current account in the credit institutions, or converted into securities, either State papers or papers guaranteed by the State, in accordance with the list drawn up by the Federal Commissariats of Finance and Labour. Interest-bearing securities must be deposited in the credit institutions.

FUNDS AT THE DISPOSAL OF THE PUBLIC HEALTH AUTHORITIES

All the sums derived from insurance contributions and intended for the payment of medical treatment for the insured, together with the fines imposed for arrears in the payment of these sums, less 1 per cent. intended for organisation expenses, are transferred to the public health authorities in accordance with the following rules.

The territorial insurance societies transmit:

- (1) a fixed proportion of the total insurance contributions to the commissariat of public health of the federal republic through the medium of the central insurance department of the republic;

- (2) the sums intended for the maintenance of local hospitals and institutions for preventive treatment to the chief of the district public health board;
- (3) the rest to the provincial social insurance authorities.

The various proportions are fixed by the law of each republic, and not more than 15 per cent. of the total insurance contributions may be spent on medical treatment.

The transport funds transmit:

- (1) 10 per cent. of the total contributions for medical benefit to the commissariat of public health of the federal republic in whose territory the health board of the railway concerned is competent, through the medium of the principal social insurance department of the republic
- (2) The rest to the health board of the railway concerned.

District Medical Benefit Funds

The district (or corresponding) medical benefit funds comprise:

- (1) the sums paid by the territorial societies;
- (2) subsidies from the provincial (or corresponding) funds,
- (3) interest, etc.

The administration of these funds is placed in the hands of a special service of the public health authorities. The funds are spent solely on providing relief for the insured in accordance with the scheme drawn up by the insurance society concerned and the local trade union. These schemes must be confirmed by the provincial (or corresponding) conference attached to the public health authorities, at which those authorities, the corresponding social insurance authorities, the trade union federation and the more important unions are represented. The estimates of expenditure are submitted to the insurance society concerned which after approval refers them to the said conference for sanction.

The Funds for the Main Lines and Railway Divisions

The transport funds for the main lines and railway divisions are made up of:

- (1) the sums paid by the local transport funds;
- (2) interest, etc.

These funds are used for the maintenance of institutions, for medical and preventive treatment intended solely for insured persons in the transport drawn up by the health board of the railway concerned. Attached to this board is a conference comprising representatives of the health board of the insurance fund for the main line or railway division and the trade union concerned.

Provincial (or Corresponding) Medical Benefit Funds

The provincial medical benefit funds consist of.

- (1) the sums transmitted to the territorial societies,
- (2) subsidies from the medical benefit fund of the republic,
- (3) interest, etc.

The administration of these funds is in the hands of a special service, the expenditure being effected in accordance with the instructions of the conference already referred to, for the following purposes:

- (1) The grant of subsidies to the district (or corresponding) funds
- (2) The organisation and maintenance of institutions for medical or preventive treatment in which all the provinces are interested and which are intended solely for the insured and the members of their families
- (3) The improvement of the medical and preventive treatment given in institutions intended mainly for the insured and the members of their families.

Funds of the Federal Republics

The medical benefit funds of the federal republics consist of.

- (1) the payments made by the territorial societies and the transport societies;
- (2) interest, etc.

The payments must be made not later than the fifth of each month by the various credit institutions, the sums thus transmitted being transferred before the fifteenth of the month to the account of the commissariat of public health.

The administration of these funds is solely in the hands of the medical benefit board in the commissariat of public health of the republic in question. The money is used for the following purposes:

- (1) The grant of subsidies to the provincial (or corresponding) funds.
- (2) The organisation and maintenance of institutions for medical and preventive treatment of general interest to the republic, which are intended only for the insured and the members of their families.
- (3) The improvement of the institutions for medical and preventive treatment which are intended mainly for the insured and the members of their families.

The sums derived from the territorial societies are spent in accordance with the scheme drawn up by the health board and confirmed by the social insurance council of the republic. The commissariat of public health of the republic keeps a special account of these sums and reports on its expenditure to the principal social insurance department of the republic, which approves the report and transmits it to the social insurance council of the republic.

The sums derived from the transport societies are spent solely on behalf of insured persons in the transport industry and the members of their families. The budget estimates are prepared by the board of the commissariat of public health of the republic concerned and are confirmed by the social insurance council of the republic on the recommendation of the delegate of the central social insurance department for transport.

The accounts of the above expenditure are submitted to the commissariat of public health and the principal social insurance department of the republic, which on the recommendation of the delegate of the central social insurance department transmits them for approval to the social insurance council of the republic.

The exact amount of the Federal reserve on 19 October 1923 is known, being 4,759,120 roubles. Moreover during the first seven months of 1924 the reserve fund received about 8 million roubles and spent 6,435,000. On 1 August 1924 the reserve fund was about 9 million roubles.

As regards medical benefit in the R.S.F.S.R. the total reserve fund was 941,672 in October 1924 and 881,132 roubles in October 1925.

In addition to the reserve fund there are current reserves made up out of surplus revenue. On 13 November 1924 the total reserve amounted to 48 million roubles, and on 19 August 1925 to 72 million roubles, i.e. at the end of 1924 it covered 70 days' expenditure, in the first quarter of 1925 76 days, in May to June 66 days and in July to August 58 days. After that date the proportion rose to 70 days, falling again to 43 days in April 1926.

Serb-Croat-Slovene Kingdom

As in Hungary, there are a centralised reserve fund and special reserves constituted by the local institutions.

The Central Workers' Insurance Institution must form a reserve fund for emergencies up to the average annual expenditure for the last five years. Until this minimum is reached, at least 25 per cent of the net revenue must be set aside for this purpose.

It will be recalled that the Central Workers' Insurance Institution is the financial unit for workers' insurance, and centralises all revenue and expenditure. In order to leave something to local initiative, however, the law provides that a specified fraction of surplus revenue must be returned by the Central Workers' Insurance Institution to the local institution. According to section 140, subsection 2 of the Act, by a decision of the general meeting of the local institution, three-quarters of the annual surplus may be invested with a view to granting additional benefits, or used for opening and maintaining hospitals managed by the institution. Such decisions must be approved by the Central Workers' Insurance Institution.

At the end of 1923 the reserve fund of the Central Institution, accumulated in accordance with section 26 of the Act, amounted to 12,091,912 dinars.

Switzerland

All the recognised funds, and therefore in particular the sickness funds in the Cantons in which insurance is compulsory, must accumulate a reserve fund out of their surplus revenue.

B. CAPITALISATION SYSTEMS

Three laws: *Great Britain, Irish Free State, Northern Ireland.*

Great Britain

The financial system introduced in Great Britain was organised with a view to reconciling as well as might be two requirements which were considered equally urgent. The first was to retain in the management of the approved societies the essential features of the friendly societies when insurance was voluntary. The second was, in spite of this, to fix a flat rate for all persons independent of the age of entry into insurance and corresponding to the lowest age of admission (16 years)

There were accordingly three principal difficulties to overcome. The first of these, which has already been mentioned, related to persons becoming liable to insurance after the age of 16 years and who ought in reason to pay a contribution rising in amount with the age of entry. The second was due to the differences which each society must inevitably experience between the standard fixed by the initial actuarial estimates and the reality, the direction and size of such differences being variable and impossible to foresee. The absolute uniformity of the contribution prohibits each society from adjusting its resources to its particular situation: it is bound to adapt itself to the rate fixed for the whole population as if that consisted of a single block of insured persons. Hence it was necessary to forestall by suitable financial means the disturbances of equilibrium that might be produced in some funds.

The third difficulty was due to the freedom on the one hand of the societies to select their risks, and on the other, of the persons liable to insurance to join an approved society or not. It will be remembered that the only condition laid down by the British law in this respect is that a society may not reject a candidate for reasons of age; it is free to use the other ordinary methods of selection, although in fact the majority of societies do not require a medical examination and do not reject applications for admission on grounds of health. Nevertheless, there is always a floating mass of persons liable to insurance, consisting of a small number of persons who have found no insurer, persons who neglect to insure, and finally those who are expelled from the society to which they belonged or who leave it. The question was how to provide for the payment of benefits to this amorphous and unstable group. For this group the Deposit Contributors' Fund was set up.

Once these difficulties are realised, the undeniable complexity of the financial system in force in Great Britain is no longer surprising. It involves a multiplicity of funds, complicated accounts, and an overlapping of credits and debits, in which it is difficult to find one's way. To this must be added the many modifications that have been introduced since the system was begun, and the general uncertainty due to the fact that the appreciation of the financial situation depends on hypotheses which are always liable to future revision. An attempt will, however, be made to give a simplified picture of the system.

To begin with, a "central bank" may be imagined into which all annual revenue is paid, contributions, State subsidies, interest on the capital kept by the bank itself, and which out of these funds finances the approved societies and insurance committees in accordance with well-defined rules and provides for the benefits for insured persons who belong to no society (deposit contributors). This bank is the National Health Insurance Fund. It takes no part in the insurance operations properly so called, but is rather a vast clearing house for all the physical or artificial persons whose business it is to manage, distribute or consume the financial resources of insurance. It opens accounts

with the approved societies, the insurance committees and the deposit contributors, and in a general way with all creditors or debtors of the National Fund.

In order to describe the mechanism of its operations, the following procedure will be adopted. The rate of the contributions and the reserves will be discussed first of all, together with the technical bases on which it rests. This will be followed by a description of the working of the bank's own funds from which it derives the moneys that it distributes. Finally, the part played by the accounts will be discussed which relate to financial transactions, real or fictitious, between the National Fund and its customers.

RATE OF CONTRIBUTION

As already explained, the rate of contribution in a capitalisation system for sickness insurance depends on the choice of a morbidity table, a mortality table and a rate of interest. These factors serve to calculate not only the premiums but also the reserves.

The original rate of 1912 was fixed by the Act on provisional bases. The technical bases used since then and until 1926 were derived from the report on the administration of insurance for 1912 to 1913.

The morbidity table used (Table of the Joint Committee, *Report for 1912-1913*, p. 583) is Watson's table (experience of the "Manchester Unity", 1893-1897, for the whole society) amended in certain respects to make allowances for the particular conditions introduced by the Act.

In the first place the Act does not provide for cash benefit during the first three days of sickness, which were included on the contrary in the "Manchester Unity" experience. Consequently, a slight reduction of the Watson table morbidity rates was made for the first six months of sickness.

Secondly, for disablement (cases of sickness lasting more than six months) a special table had to be drawn up to apply from the outset. In point of fact the Manchester Unity tables related to a society of some age, whose disabled members became disabled on varying dates, some therefore being disabled already. All the insured persons under the National Insurance Act, on the contrary, were presumed to be able-bodied when the Act came into force, since they had to be employed in an occupation subject to the Act.

Thirdly, the cash benefit payable under the Act is not granted in cases of disablement covered by the Workmen's Compensation Act. Now, during the period 1893-1897, which closed at about the time the first Compensation Act came into force, disablement due to industrial accidents was compensated by the Manchester Unity in the same way as all other disablement due to sickness. This should have led to another reduction in the Watson table rates. On the other hand, persons insured under the National Insurance Act certainly include a larger proportion of bad risks than the members of the Manchester Unity, and it was therefore assumed that these two factors, which are difficult to estimate, would roughly cancel each other out, and that the Manchester Unity table, although including a certain proportion of incapacity due to industrial accidents might be regarded as an acceptable measure of the morbidity rate of the insured population if such cases of incapacity are excluded.

Finally, the morbidity and disablement rates of the Watson table, as already indicated, were subjected to a general loading in order to allow a margin for differences between the societies and for any increase in the morbidity in respect of which benefit is paid that might follow from the actual introduction of the law. This loading was fixed at 12.745 per cent and in practice brought the insurance rate to the figure fixed by the 1911 Act.

The morbidity table of 1912-1913 was modified in 1926 as follows: the loading of 12.745 per cent. of the morbidity rates was given up, as the experience of 1921 to 1923 had shown it to be unnecessary. At the same time a second table was constructed for female morbidity, distinguishing between married and single women. This table was based on the observation of 400,000 insured women during 1923.

A first mortality table (1912-1913 report) was specially constructed for the administration of the Act to make allowance for the substantial reduction in the death rate which had already been observed at that date. It was based on the deaths recorded in England and Wales from 1908-1910 and the results of

the 1901 census combined with the estimated population on 31 March 1911. This table in turn was found too rapid. Since 1926 use has been made of the survival table for the population of England and Wales based on the 1921 census and the deaths registered in 1920 and 1921.

The rate of interest assumed to be earned by the funds and credits of approved societies was 3 per cent. until 1 January 1926. The new basis adopted as from this date assumes 4 per cent., but the interest actually credited on the outstanding reserve values (see below) remains at 3 per cent.

It will be remembered that the risks covered include not only sickness and disablement, but also maternity. Moreover, the benefits sometimes depend on the civil condition of the insured person. The estimates of the costs therefore require additional demographic data to those mentioned (marriage rate, maternity rate). But it is not proposed to discuss these questions here, or to examine the various special cases in which the rules generally followed for calculating the present value of the costs of insurance have to be modified.

The rate of contribution adopted has varied frequently since the Act came into operation, either because the Act has itself altered the obligations of the parties, or because it seemed necessary to go back on certain estimates.

The successive rates of contribution for persons insured under the general system were as follows:

	Total weekly contribution		
	1911	1920	1926 ¹
	d.	d	d.
Men	7	10	9
Women	6	9	8½

¹ These rates came into force on 4 January 1926.

The contributions quoted in this table are the total contributions payable and only a portion of them (in 1920 77/100 d. men and 71/100 d. women, and in 1926 79/100 d. men and 71/100 d. women) represents the net actuarial premium at age 16 to provide the proportion of benefits actually payable by the societies after deducting the State grant. The remainder of the contribution is divided into two portions, the first of which provides for interest on and redemption of reserve values as explained later, whilst the rest is used to provide protective funds (the Contingencies Funds and the Central Fund). The increases in the net actuarial premiums at 1926 are the result of many factors. In the first place until 1 January 1928 the contributions were payable, and sickness and disablement benefits were receivable, until the age of 70. As from that date, however, the Pensions Act confers pensions at 65 and the contributions and sickness and disablement benefits under the Health system are consequently limited to that age. This limitation, by cutting out the heavy morbidity between ages 65 and 70, appreciably reduces the actuarial premium at 16. On the other hand under the 1926 Act the proportion of benefits to be borne is increased as from 1 January 1926 from 7/9 to 6/7 (men) and 4/5 (women) and, further, the annual charge for medical benefit is increased as from 1 January 1927 from 10s. to 13s. per head. Finally the adoption of new technical bases as from 1 January 1926 also affects the net premium. The lighter mortality for both men and women and the heavier morbidity for women tend to increase the premium whilst the higher rate of interest and the lighter morbidity in the case of men have the reverse effect.

As regards the amount of the reserves, the calculation of which is a fundamental feature in a system of capitalisation, a distinction must be made between two cases, that of persons already insured and that of persons who enter into insurance after the age of 16 years. It has already been explained that when a person of the latter class pays the same contribution as a person who enters at the minimum age, the society he joins should receive the amount

of the reserve which would have been accumulated if he had paid contributions from the age of 16 (reserve value). But owing to the various provisions of the Act this reserve value is not equal to that for an insured person of the same age who entered at 16, for the Act provides for a qualifying period during which the person who enters into insurance and pays his contribution is not entitled to benefit, whereas one already insured who has passed the qualifying period may claim benefit without delay. It follows that the present value of the costs, and therefore the reserve, is higher for the latter. This leads to a distinction between the reserve value corresponding to the age of admission of a person who enters after 16, and the transfer value corresponding to a person of the same age who is already in insurance. The term "transfer value" is derived from the fact that this reserve represents the sum which is transferred if he changes his society. The table below gives the reserve value and transfer value for men at various ages according to the tables calculated on the bases accepted in the 1912-1913 report:

Age	Reserve value for persons entering at the age stated			Transfer value for persons of the age stated insured for not less than two years ¹		
	£	s	d	£	s	d
17			10 0		—	
18	1	0	0	1	6	0
20	2	0	0	2	8	0
30	6	6	0	6	18	0
40	10	8	0	11	2	0
50	14	16	0	15	14	0
60	13	16	0	15	12	0

¹ There are also tables of transfer values for persons who have been insured for less than two years.

RESOURCES OF THE NATIONAL HEALTH INSURANCE FUND

The receipts from contributions are paid into the National Health Insurance Fund and in the first place are credited to the "Stamps Sold Account" which is named after the manner of collecting contributions (by affixing stamps to the insurance card). As and when stamped cards are surrendered by societies to the Central Department sums are transferred from the Stamps Sold Account to the credit of the societies. Normally, all the stamps bought should be used sooner or later for the payment of contributions. There will always be a slight surplus however, owing to the loss or destruction of stamps, or the failure to use them from whatever cause. Provision has been made for any such surplus to be carried, in the main, to the Central Fund referred to below, but it has been also used to compensate the societies for arrears of contributions remitted during periods of exceptional trade depression in the case of involuntarily unemployed members.

The moneys contributed by the State are paid into the National Health Insurance Fund as funds are required to be issued to societies for the payment of benefits and administration expenses.

The sums standing to the credit of societies which are not immediately required for payment of benefits and the cost of administration are invested either by the Central Department or by societies. The account of each society is balanced periodically, and of the sum found to be available for investment one-half is invested by the Central Department with the National Debt Commissioners and carried to the society's credit in an account called the National Health Insurance Investment Account. The other half of the sum available for investment is either issued to the society for investment by them, or, at the society's request, is invested by the Central Department on behalf of the society.

Apart from the sums standing to the credit of individual societies in the National Health Insurance Fund, there is also a fund called the Central Fund.

The fund was formed by retaining a proportion of each contribution, instead of crediting the amount to the societies, together with a State subsidy. It is also credited with surplus moneys from the Stamps Sold Account not otherwise required. The purpose of this fund is to meet deficiencies on valuation which cannot be made good by societies' own contingencies funds. It is a condition of a grant from the Central Fund, however, that the deficiency shall be shown to be due to special causes beyond the control of the society. Very little call has been made on this Fund and its resources were so ample that since 1921 contributions to it have been suspended. Moreover, for the period from 1922 to 1926 a part of the accumulated money, mainly that derived from the Stamps Sold Account, was used to supplement the sums otherwise available for the provision of medical benefit.

Finally, there are two central accounts or funds for transactions connected with reserve values and transfer values. These are the Reserve Values Apportionment Account and the Reserve Suspense Fund. Their functions cannot be explained clearly until the accounts of the societies have been described. It may be stated now, however, that the Reserve Suspense Fund may also be put to another use than that originally provided in the Act. Under the 1926 Act the amount by which the position of any society in deficiency has been made worse owing to the provisions of the Act may be made good out of the balance of the Reserve Suspense Fund or, if this proves inadequate, out of the Central Fund.¹

TRANSACTIONS BETWEEN THE NATIONAL FUND ON THE ONE HAND AND THE APPROVED SOCIETIES, INSURANCE COMMITTEES AND DEPOSIT CONTRIBUTORS ON THE OTHER

Current Account of Each Approved Society

In the first place, this account is credited with the amount of the contributions payable to the society as and when they fall due, the amount being verified by the stamped insurance cards. As explained above, this sum is not the total contribution, however, but only a certain part, which since 1926 has been 7.9d. for men and 7.7d. for women, that is to say, the theoretical premium.

The account is also credited with the State subsidy, or $\frac{1}{7}$ of the cost of benefit and administrative expenses for men and $\frac{1}{5}$ for women.

Further, the account is credited with the contingencies fund of the society. A deduction of 0.25d. (for both men and women) is made from the difference between the rate of contribution and the theoretical premium, and this is placed to the credit of the society under the head of "Contingencies Fund". The society is not immediately entitled to dispose of this credit, which does not immediately form part of its benefit fund. It will be remembered that once every five years the financial situation of each society is subjected to actuarial examination. This examination leaves the contingencies fund out of account. If it reveals a deficit with respect to the value of the probable costs which the society will have to meet, the latter may then make use of this particular credit. If there is no deficit or if the deficit does not exhaust the whole of the credit, the balance is withdrawn from the contingencies fund and transferred to the society's own insurance fund, thus figuring among its benefit funds when the next examination is made.

The account is also credited with the interest on the sums invested for the society by the Central Department and on sums invested temporarily.

To the account are debited the sums in cash remitted to the society for the payment of benefits and administrative expenses, those remitted for investment by the society itself, those to be used for investment in the Investment Account, and those due from the society to the insurance committees for providing medical benefit.

¹ For the reasons already given, the Navy, Army and Air Force Insurance Fund will not be discussed. The Deposit Contributors' Fund is dealt with on page 508.

There remains the question of the transactions connected with the reserve values of insured persons entering into insurance after the age of 16 years and joining an approved society, and of the transfer values of insured persons who change their society.

Reserve Values. — When the system was started persons who entered into insurance at an age above the minimum age for admission formed the large majority of the insured. Later, on the contrary, they constituted an exception. Hence two methods were adopted, according as entry took place during the first fifteen months of working or after. If an insured person of 17 years or more entered a society during the first fifteen months of working, the reserve value corresponding to his age of admission was credited on paper to the society, not in its current account but in a special account, the reserve values account (one account for each society). Thus originally the credit was purely imaginary. But at the same time there was no reason to fear that this fact would mean that the resources of the society were insufficient to meet its current obligations. For many years, in the absence of reserve values, the deficit too would remain simply a paper deficit. It was therefore enough gradually to transform the imaginary credit into real values on which the society might draw later. This procedure, which would be inadmissible in private insurance, at least for a liability of such dimensions, is allowable in public insurance, for in the latter there is no need to offer commercial proof of financial stability at any moment, and since the system has both perpetuity and coercion in its favour, it may take its time in drawing on the contributions it imposes for accumulating assets to balance the debts which, although they already exist, cannot immediately be claimed.

The next question is therefore how this asset is gradually formed. Of course, the sum in question is increased every year by the interest at the fixed rate on the part not yet converted into a real credit. The problem is therefore the simple one of the repayment at compound interest of an initial debt. Only, the method of repayment prescribed by the Act is not based on the payment of constant annuities. It has already been shown that after the payment into the contingencies fund there is still a certain sum available out of the difference between the rate of contribution and the theoretical premium (since 1926 0.85d. for men and 0.55d. for women). All these surpluses are placed to the credit of a central account, the Reserve Values Apportionment Account. The assets of this account are distributed annually among the societies in proportion to the unredeemed portion of their reserve values. The amount remaining after these reserve values have been credited with interest at 3 per cent. is used for redemption. This process of redemption means a corresponding reduction in the imaginary credit in the reserve values account of each society, a corresponding real credit being placed in the society's current account.

The loss of financial equilibrium due to the flat rate of contribution independent of the age of admission is thus gradually repaired by a process of collective capitalisation¹, since the present value at the outset of all the deductions to be made from the premiums equals that at the outset of the reserve values. But with the rate of contribution adopted these deductions are possible only because the State pays for part of the benefits. Thus in point of fact it is the State subsidy which appears to pay for the constitution of the reserve values, so that it may well be asked why this roundabout way was adopted instead of drawing directly on public funds. The reason was the desire to give the State subsidy from the outset its normal function, that of covering a certain proportion of the cost of benefits. When the total reserve values have been redeemed, the State will still continue its subsidy, and then either the rate of contribution may be reduced or the benefits increased. Ultimately, therefore, it is the persons who insure during the earlier years who pay for the reserve values, since those who insure later either receive increased benefits at the same price or the same benefits at a lower price.

The total reserve values credited to societies in the first fifteen months were £69½ millions. At the second valuation date they amounted to £97½ millions.

¹ Or, if preferred, by the annual distribution of a certain proportion of the part of the reserve values not yet redeemed.

In the interval the following changes had occurred. Under the 1920 and 1922 Acts £50½ millions new reserves were credited. In respect of new entrants in the period £29½ millions were credited whilst £38 millions were withdrawn in respect of lapses. £11½ millions were redeemed in the period and finally £2·5 millions were withdrawn in respect of Irish Free State societies, in consequence of the severance of the system in that country.

It is estimated that the Pensions Act of 1925 will mean a reduction of about £37 millions, whilst further changes to an amount not yet specified will follow the 1926 Act. In addition the balance of the Reserve Suspense Fund, estimated to amount to £17 millions by the end of 1926, will be used in extra redemption.

As regards the insured persons who enter into insurance after the age of 16 years, and after the first fifteen months of working, it is assumed that the obligations represented by their reserve values approximately balance the profits which the societies make on cancelled contracts due to persons leaving insurance (other than by death or because they have reached the age limit). The reserves thus given up are paid into the Reserve Suspense Fund, which forms part of the National Health Insurance Fund and out of which the necessary payments are made. In point of fact, this fund has hitherto proved amply sufficient for the purpose.

Transfer Values. — The Reserve Suspense Fund is also used for transfers of reserves from one society to another. When a member leaves a society, either because he passes out of insurance or because he changes his society, his transfer value is paid into the Fund. If he enters a society, having already been a member of another, his transfer value is placed to the credit of the current account of the new society and taken out of the Fund.

The above account will have shown that the technical processes of capitalisation do not directly affect the financial management of the approved society itself. The latter merely draws on its credit in the National Fund according to requirements and turns the moneys entrusted to it to the best possible account. Its actual financial situation is revealed at the end of each five-year period by the Government actuaries.

Current Account of Each Insurance Committee

Insurance committees are responsible for providing medical benefit for the members of approved societies. The account of a committee is credited with sums corresponding to the debts of the approved societies to the committee by means of transfers from the societies' current accounts. It is debited with all sums in cash paid to the committee by the National Fund.

Current Account of Each Deposit Contributor

A person who is liable to insurance but does not belong to an approved society still pays the contribution at the fixed rate, as also his employer. These contributions are transferred, in full, into a central fund, the Deposit Contributors' Fund, which forms part of the National Fund. An individual account is opened for each deposit contributor, which is credited with his contributions (without deduction) and the State subsidy and debited with the cost of benefits and a certain share in administrative expenses. A deposit contributor cannot receive benefits in excess of the credit in his account.

If a deposit contributor joins an approved society, the credit balance of his current account is transferred to the Reserve Suspense Account, which pays the society the transfer value of the new member. If a deposit contributor settles permanently abroad or dies, he or his dependants receive half the balance of the account, the remainder being paid into the Reserve Suspense Fund.

For this group of persons there is therefore no insurance properly so called, for on the one hand there is no collective compensation for risks, and on the other no guarantee for the benefits prescribed by the law.

STATISTICS OF INVESTED FUNDS

The following tables contain statistics of the invested funds and the Central Fund:

	INVESTED FUNDS (In thousands of £)				
	1922	1923	1924	1925	1926
Invested by National Debt Commissioners	61,713	67,035	69,085	74,209	
Invested by or for the approved societies. .	36,827	40,089	44,623	50,016	
Total . . .	98,540	107,124	113,708	124,225	
	£	£	£	£	
Amount per insured . .	6 5	7.1	7 5	7 9	

INTEREST ON INVESTED FUNDS

	Amount (Thousands of £)	Amount per insured £
1914	618	0.05
1915	899.	0.06
1916	1,199	0.08
1917	1,628	0.1
1918	2,265	0.2
1919	2,721	0.2
1920	3,271	0.2
1921	3,695	0.2
1922	4,125	0.3
1923	4,751	0.3
1924	5,281	0.3
1925	5,633	0.4

CENTRAL FUND

The balance of the Fund at the end of 1925 was about £2,500,000.

Irish Free State

The general organisation of the financial system is the same as in Great Britain.

The total weekly contribution is 8d. for men and 7d. for women (it will be remembered that there is no medical benefit). Out of the contribution the societies are credited with 5⁷/₈d. for men and 5¹/₈d. for women. The remainder, or 2²/₈d. for men and 1⁴/₈d. for women, is divided between the society's contingencies fund (⁵/₈d. and ²/₈d.) and the fund for the redemption of the reserve values (1²/₈d. and 1²/₈d.).

Societies with a membership of under a thousand may form a joint contingencies fund by amalgamating half their respective contingencies funds.

The Central Fund serves the same purpose as in Great Britain. No payments have been made into it since 1918.

In 1926, the total accumulated funds amounted approximately to £2,500,000 and the interest on capital to £116,000. The annual income of the contingencies funds is about £27,000. The Central Fund amounts to £72,000 or about 3 s per insured person.

Northern Ireland

The total weekly contribution is 7d. for men and 6¹/₂d. for women.

Northern Ireland, like Great Britain, has now introduced a system of contributory pensions (widows, orphans and old-age) which has involved similar modifications in the sickness insurance system (reduction of the old rates).

An Economy Act similar to the British National Health Insurance Act of 1926 has been adopted in Northern Ireland (reduction of the State subsidy)

Pending completion of the separation of the Health Insurance system in Northern Ireland from that of the rest of the United Kingdom, no details of the accumulated funds in Northern Ireland are available.

§ 7. — Guarantees

The term " guarantees " is here taken to mean the various measures adopted for securing the regular working of insurance when a fund happens to suffer a deficit which cannot be met out of reserves by raising the rate of contributions to the authorised maximum or by reducing benefits to the legal minimum. The chances that such a deficit will be incurred and the methods of dealing with it vary considerably according as the finances of insurance are under single control or are managed by a large number of separate independent funds.

When the finances are under single control, the compensation of the risks is theoretically effected in the most favourable manner, and although systematic deviations (for instance, deviation due to epidemics) must always be taken into account, chance deviations may be considered practically eliminated. There are two other very important advantages usually connected with this form of management: firstly, much lower administrative expenses; secondly, strong centralisation of insurance, normally allowing the constitution of large reserves. The latter, while representing a considerable margin of security, increase the scope of social insurance as regards sanitary medical and curative and preventive institutions.

If, on the contrary, a large number of separate funds enjoy financial autonomy, the causes which may lead to a deficit here and there are both more numerous and more powerful. They may be divided into four main groups.

In the first place, chance deviations are to be feared all the more if the membership of the fund is small. It is difficult to fix reasonably the minimum below which the compensation of risks would take place with too much irregularity. Moreover, in the case of a risk so frequent as that of sickness, this minimum should be fairly low. Without having to employ the theory of probability, it is clear that if a risk occurs on an average once a year for one person in ten, a satisfactory compensation will be obtained by grouping a far smaller number of insured persons than for a risk affecting, for instance, one person in a hundred. Assuming that the morbidity rate in days, divided by 365, represents the mathematical probability that a day of risk taken at random during the year will be a day of sickness, and that it is practically certain that a chance deviation will not exceed four times the standard deviation (*écart*

quadratique moyen), then calculation shows that for a morbidity rate of, say, ten days and a membership of a hundred persons, the real morbidity may not be expected to exceed the calculated morbidity by more than 12.5 per cent., which is still a considerable deviation, and disturbing to financial equilibrium. With 500 insured persons, this deviation is reduced to 6 per cent. of the calculated morbidity, with 1,000 to 4 per cent., with 10,000 to 1.25 per cent. The minimum of a hundred insured persons often fixed by law thus seems rather low. Admittedly, however, other considerations intervene, in particular the possible difficulty of obtaining a larger membership, over not too wide an area, in sparsely populated districts.

But the purely chance deviations are not those most to be feared. The real cause of inequality between the burdens of the different funds lies chiefly in the fact that the composition by occupation, sex and age will differ considerably from one fund to another, and often in any one fund from one year to another. Recalling what was said above on the variation of morbidity with age, sex and occupation, some idea of the size of the deviations due to this cause will be obtained. The danger will be particularly serious if, in spite of the large number of institutions, the rate of contribution is uniform, and calculated for the population as a whole. In this respect those laws which leave each fund to fix its own rate, at least within certain limits, possess a definite superiority.

Thirdly, the financial management itself should be more or less satisfactory. The funds may be more or less well invested. Some funds will be extravagant, others very thrifty, even too thrifty. However carefully the supervisory institutions perform their duties, they cannot altogether avert inequalities.

Finally, a certain number of funds will have no means of meeting these various threats to their financial equilibrium but resources derived from reserves which are too small, and have often been drawn on before they reach a reasonable level. If to this is added the fact that the administrative expenses are proportionately higher in the case under consideration, it is tempting to conclude that the balance is decidedly in favour of single management, or at least management by a small number of large funds.

The advocates of small funds, on the other hand, contend that the local organs of centralised and unitary insurance systems, being simply offices for collecting contributions and making payments, feel themselves less directly interested in zealously husbanding the resources of insurance. They recall that the risk of sickness is

very "individualised", and requires a direct, individual, severe and yet friendly supervision of the sick, and they maintain that this discreet but effective supervision can be carried out more easily by small funds. This argument of the efficiency of supervision is no doubt well founded for rural funds and small urban funds, but it loses much of its value for insured persons in industrial centres.

These being the most usual causes which may disturb the financial equilibrium of insurance, an account may now be given of the remedies ordinarily employed. Of these there are roughly two kinds. The first constitutes what may be called guarantees "of the first degree", which apply only if insurance is not financially unified. They consist in qualifying in some respects the financial independence of the separate funds. Thus, several funds may be required to bear certain risks in common, either by creating one or more "compensation funds" or by reinsurance. The true system of mutual reinsurance—that is to say, the cession by one fund to another of a certain proportion of its premiums and a corresponding proportion of its risks—is apparently not to be found in any country. Although the idea is attractive, its realisation meets with various difficulties (different rates of contribution, complication of accounts) and especially with the fact that the contributions do not represent the premiums for the risk. The efficacy of the remedies just enumerated is certain. Their expediency has often been disputed, and there can be no doubt that they too involve certain dangers. If by simply appealing to a compensation fund a sickness fund feels itself automatically guaranteed against deficit, it may perhaps relax its supervision of the sick, and there is an incentive to extravagance. Moreover, any mistakes in management do not meet with the natural penalty.

As for the guarantees "of the second degree", these consist in the payment of benefits by third parties, such as the State, the local authorities, or even employers, when the institution which should pay them suffers a deficit. These remedies are more open to the objections just referred to than those already described, for the funds then drawn on are altogether outside insurance, and are not even constituted out of the financial resources of the sickness funds. In works funds, however, which are usually organised on the initiative of the employer, and actually placed under his management, it seems fair that he should be the final guarantor of payments. As for the State guarantee, it is almost a word to conjure with. It has the advantage of convincing the payer of the premium that he will in no case lose the rights to which he is entitled by the sacrifices

he has made. Yet very few laws have recourse to this method. The reason is that all sound systems of social insurance must rest on the principle of equilibrium between revenue and expenditure.

These somewhat theoretical considerations may be completed by a brief account of the solutions adopted in the laws of the different countries. As already explained the whole problem is dominated by the extent to which the financial management of insurance is unified. A subsidiary part is played by the rate of contribution, whether it is uniform for the whole country or varies locally or from one institution to another. The classification of the laws studied from these points of view may therefore first be indicated, as shown in the table below.

Financial management	Rate of contribution	
	Uniform	Variable locally or from one institution to another (between certain limits)
By a single fund	Belgium (seamen), Bulgaria, France (seamen), Russia	Serb-Croat-Slovene Kingdom ¹
By several independent funds	Chile, Czechoslovakia, France (miners), Great Britain, Hungary, Italy (new provinces), Irish Free State, Northern Ireland, Portugal, Roumania (former Kingdom and Bessarabia, Ardeal), Switzerland (Appenzell, Outer Rhodes, Basle Town, St. Gall)	Austria, Esthonia, France (Alsace - Lorraine), Germany, Latvia, Lithuania, Luxemburg, Norway ² , Poland, Roumania (Bukovina), Switzerland (Appenzell, Inner Rhodes)

¹ In certain respects, however, the Central Workers' Insurance Institution allows the local institutions limited financial initiative.

² As a matter of fact the so-called "normal" rate is used by all the funds.

GUARANTEES OF THE FIRST DEGREE (LAWS ALLOWING SEVERAL INDEPENDENT FUNDS)

Amalgamation of Funds

In most laws the supervisory authorities reserve the right to order the amalgamation of a fund whose financial situation appears seriously compromised with another fund. The members are transferred *en bloc* to the new fund, which takes over all the obligations of the old. As an instance, reference may be made to the provisions in force in Germany, which also apply to Alsace-Lorraine in France.

If in a local fund the increase in contributions decided on by agreement between employers and insured persons on the committee is insufficient to cover the regular benefits, the Superior Insurance Office proceeds to amalgamate the fund with one or more other local funds (Federal Insurance Code, section 389).

Common Reserve Funds

The existence and working of these have already been discussed in this Chapter. It may be recalled that in countries where the system is that of several independent funds, common reserve funds are to be found in Hungary and Norway. Conversely, in the Serb-Croat-Slovene Kingdom, where the system of insurance is centralised but local institutions are allowed a certain degree of financial initiative, they may accumulate their own reserves. In the three countries with systems of capitalisation (Great Britain, Irish Free State, Northern Ireland) joint funds play an important part which need not be re-examined here.

Reinsurance

There is one reinsurance fund in Switzerland, in the Canton of Appenzell, Outer Rhodes. All the public funds in the Canton are insured with a reinsurance fund with a view to covering their risks, and partially covering any future deficit (Regulation promulgated by the Council of State on 23 May 1919). They pay into this fund 2 per cent. of the contributions they collect. In addition the State makes an annual contribution to the reinsurance fund which must not be less than three times the sums paid by all the reinsured funds plus various contributions provided for in the Sickness Insurance Order (sections 11 and 33). In return the reinsurance fund guarantees the reinsured funds a contribution towards their deficits in so far as the latter exceed 10 per cent. of the total contributions collected during the year, as well as the payment of the cantonal contributions towards the insurance of necessitous persons, the compulsory insurance of women and children, and nursing allowances. In other words, the fund acts as a reinsurance fund properly so called only for the purpose of covering deficits when these exceed a certain proportion of annual income. Otherwise it acts simply as an intermediary between the Canton and the sickness fund (payment of cantonal subsidies).

In Russia the Regulations of 15 January 1924 set up a system of superimposed funds (insurance societies' funds, provincial

funds, funds of the federal republics, and the Federal Fund). Although they do not act as reinsurance funds properly so called, they serve in case of need to cover at least part of the deficits of the subordinate institutions. Thus the provincial funds, whose resources are derived from the surpluses of the insurance societies, fines, interest on capital, etc., are entitled to use their resources to assist funds with a deficit either by granting a subsidy or by transferring to them the surplus obtained by other societies. Similarly the Central Social Insurance Department may, in case of need, use the Federal Reserve Fund to assist the provincial funds.

GUARANTEES OF THE SECOND DEGREE

A State subsidy established by law is to be found only in France for seamen's insurance. If the normal or incidental resources for a given year, together with (unlimited) recourse to the reserve fund are insufficient to meet the obligations for that year, the State must furnish the sum needed to meet the deficit. Although this payment takes the form of a repayable advance (without interest), repayment depends on surpluses being obtained in future years, and the grant seems to be made quite independent of any regulations as to the methods or even the possibility of repayment.

Recourse to other persons, public or private, is provided by law in France (Alsace-Lorraine), Germany, Luxemburg, and Switzerland (Appenzell, Outer Rhodes). In Germany (as in Alsace-Lorraine), if the amalgamation of local funds is insufficient to provide for the payment of compulsory benefits, the federation of communes must make up the deficit out of its own resources. In a works fund or guild fund, if an increase of contributions up to 10 per cent. of the basic wage is insufficient to provide for the payment of compulsory benefits, the necessary sum is provided by the employer or the guild, as the case may be. Similarly in Luxemburg, in the employers' funds, if the payment of benefits cannot be made out of maximum contributions, the head of the undertaking must meet the deficit out of his own resources, and cannot require repayment. In Switzerland (Appenzell, Outer Rhodes) the communes must cover the deficit of the year's working of public funds to the extent that it is not covered by the reinsurance fund.

CHAPTER III

FINANCIAL MANAGEMENT

In this Chapter has been brought together information relating to various questions which could not be examined in previous Chapters without interrupting the logical development of the ideas. These questions include:

- (1) the collection of contributions;
- (2) the investment of the funds of insurance institutions and the composition of their assets;
- (3) the cost of administration;
- (4) the financial and actuarial control of the working of an insurance system.

§ 1. — Collection of Contributions

Under this head are included the various measures intended to render the legal obligation to pay contributions effective, on the one hand, and, on the other, the methods of making payments in discharge of the obligation. The payment of contributions at regular intervals and the procedure adopted for recovering overdue or unpaid contributions are only referred to incidentally, but laws which confer on social insurance contributions the character of public taxes are mentioned.

MEASURES TO ENFORCE THE PAYMENT OF CONTRIBUTIONS

Where insurance is based on the principle of a dual contribution from employers and workers, the insurance institution is confronted in theory with two debtors, the employer and the worker; but practical experience has shown that this duality has considerable drawbacks. Ordinary methods of enforcing payment, by summons or distraint, even if reinforced or rendered less cumbrous by adopting a special procedure for such cases, are generally only effective against employers. As regards the great mass of the insured, the public authorities would soon be deprived of any effective

means of enforcing payment in the face of general hostility or negligence. The forcible recovery of large sums distributed among a considerable number of debtors whom it would prove exceedingly difficult to trace is in practice impossible. In certain special schemes of insurance by industry where the workers are inspired by a traditional spirit of thrift and foresight, separate liability on the part of employers and workers may involve no difficulties liable to compromise the regular payment of contributions. In the case of a general insurance scheme, on the contrary, it will prove to the obvious advantage of the efficient working of the system to make the employer liable for the entire amount due, both from himself and his employees. This is the principle known as deduction at source (in this case from wages).

The principle may be applied in one of two ways: employers are either required to deduct the amount due to the insurance institution from wages when these are paid, or the security enjoyed by the insurance institution is reinforced by making the employer liable for the payment of the entire contribution, out of which he is only authorised to recover that part for which the worker is liable when his wages are paid ¹.

¹ The well-known case of the French Workers' and Peasants' Pensions Act illustrates the necessity for defining the rights and duties of the employer in the law itself as clearly and as accurately as possible. Though sickness insurance itself is not directly affected by this instance, it may not be out of place briefly to recall the circumstances in which the liability imposed by this Act became a dead letter, from the evidence contained in the report on its application for 1911-1912.

Section 3 of the Act provided that "contributions from workers shall be deducted by the employer from wages at the time of payment", section 23 that "the employer or worker by whose fault there is failure to affix stamps as provided in the present Act shall be liable to a fine . . . The employer who has been unable to affix the aforesaid stamps can discharge his liability for the amount due by paying it at the end of the month . . . to the Registrar of the *Juge de Paix's* court, or to an approved insurance institution to which the insured belongs". As soon as the Act was put into force certain employers held that they were entitled, under section 3, to deduct the amount of the workers' contribution from the wages of employees who failed to hand in their cards. Certain wage-earners, from whose wages the amounts in question had been deducted, then brought an action against their employers before the *Conseil des Prud'hommes* claiming the return of the amounts so deducted. This tribunal, both at Paris and Marseilles, found in favour of the employees; and the decision was, on appeal from the employers, upheld by the Civil Chamber of the Court of Cassation (decision of 11 December 1911), "on the ground that there are no provisions in the Act authorising an employer to decide whether his employee's refusal to pay is legitimate or not, and conferring on him the right to compel the latter to consent to a diminution of his wages". Some employers had, on the contrary, refused to make the necessary deduction when their employees failed to hand in their cards on pay day; and when these cases came before the Criminal Chamber of the Court of Cassation it was held, in a judgment dated 22 June 1911, that an employee's failure to hand in his annual insurance card constituted a "default" on the part of the latter

The best way of applying the principle of deduction at source is to make the employer solely liable, both civilly and criminally, for the payment of contributions. This is why insurance institutions in many cases completely ignore the insured in connection with the payment of contributions, and are not even empowered, if the employers fail to pay, to recover the contribution due from the worker out of any sick benefit for which the latter may eventually become entitled. Socially and economically the application of this principle involves one consequence which is worthy of note: namely, to isolate and emphasise that portion of the worker's wages applied to social insurance, so that a wage-earner is not at liberty freely to dispose of that portion of his wages which represents his insurance contribution. This is why some wage-earners are reluctant to admit that it really constitutes part of their remuneration.

A brief summary is given below of the principal legislative provisions adopted in various countries, which should assist the reader in understanding the real nature of the general principles explained above.

With the exception of *Switzerland* (exclusive of one Canton) where sickness insurance does not apply mainly or solely to wage-earners, *Russia* where the workers pay no contribution, and, lastly, the special system applicable to miners in *France*, the principle of deduction at source is universally applied, with various exceptions and modifications.

In *Austria* every employer is required to pay the total amount of contributions due under the Act or in accordance with the rules of the fund, in respect of all compulsorily insured persons employed by him, at the dates specified by the rules.

Employers only are hable for the payment of contributions to sickness insurance funds, which are not in consequence empowered to recover from the insured. Nor is a fund entitled to deduct the amount of any contributions not paid by an employer from sickness benefits to which the insured is entitled. The only exception to this rule, under Austrian legislation, is that where an insured person makes use of the liberty to choose his own insurance institution and joins an association sickness fund (substitute fund), contributions due to the fund shall be paid by the insured and that part of the contribution for which the employer is liable repaid by him to the insured.

which, by rendering it impossible for the employer to comply with the required formalities, exonerated him from all criminal liability. In these circumstances any person theoretically liable to insurance can, by committing a default for which there is no effective remedy, decide for himself whether he shall be insured in fact. Further, as the latter portion of section 23 referred to above only constitutes a *facultas solutionis*, the wage-earner's failure to fulfil his share of the obligation results in the employer being in turn freed from his. The Act lays down the principle of deduction at source but in a form which gives too much latitude to interpretation, so that the employer's and wage-earner's respective obligations are not sufficiently closely linked up to enable a single person to be made liable for the payment of the contributions.

In *Belgium* (seamen's insurance) the Marine Commissioners are empowered to deduct contributions from wages when the crew of the vessel are paid off. In cases where they are not discharged before a Commissioner, the master is personally liable for deducting the amounts due, and handing them over to the Commissioner. The latter is responsible for transmitting both the shipowner's contributions and deductions he has made or received from the master to the treasurer of the fund.

In *Bulgaria* employers are required to deduct the contributions due from employees and workers for the entire week, in one single payment on pay day, independently of the number of days worked during the week.

If a worker or employee ceases work during the week, the employer must deduct from his wages an amount corresponding to the days during which he was not at work. The insured is then entitled to apply for a refund of this amount from his new employer.

In *Chile* employers are liable for the payment of insurance contributions at the time when wages or salaries are paid.

In *Czechoslovakia* employers are required to pay both contributions to the insurance institution and are empowered to deduct the wage-earner's contribution by deducting the amount due for the corresponding wage period on pay day. Employers who fail to exercise this right are only entitled to deduct the amount on a subsequent pay day provided not more than a month has elapsed since the pay day in question.

There is another interesting and important provision in the Czechoslovak law, which provides that where an employer has omitted to pay the contribution, the insured is entitled to pay it in his stead, and to obtain reimbursement of the amount payable from the employer.

In *Estonia* heads of undertakings are entitled to deduct the workers' contributions on pay day from their wages, and are required to pay the amount to the sickness insurance fund during the following week, together with their own contribution.

In *France* the legal provisions as regards Alsace and Lorraine are similar to those prevailing in Germany. As regards the special systems of *seamen's insurance* the method adopted is very similar to that existing in Belgium. Employers' and workers' contributions are levied at the time when the crew of the ship is being paid off before the Administrator of the naval sector. The amounts payable as contributions are paid to the Administrator by the shipowner or master on behalf of the persons in their employ and under their responsibility.

In the event of the crew being paid off abroad, contributions are levied by the consular representative by means of bills drawn on the shipowner to the order of the treasurer of the *Caisse des Invalides de la Marine*.

As regards *miners' insurance* the Act of 1894 expressly stipulates that contributions levied for the purpose of providing old-age pensions shall be collected by deduction at source; section 6 of the Act provides that relief funds (sickness insurance funds) shall be maintained by a deduction from the wages of the employee or worker, but whether deduction shall take place at the source is not specified.

In *Germany* employers are required to pay the contributions due from insured persons in their employment to the insurance fund concerned at the dates specified in the rules, while compulsorily insured persons are, in return, required to agree to the deduction of their share of the contribution from their wages on pay day.

Amounts deducted must be equally distributed over the wage periods to which they correspond. If no deduction corresponding to a given wage period has been made, the amount in question can only be deducted at the date when the wages for the succeeding period are paid, unless the delay in the payment of the contribution was not attributable to the employer.

But the principle of deduction at source is departed from, under German law, in one instance exceptionally, and the principle of dual liability restored. For the Insurance Office may, on application from an insurance fund, decide that employers who are in arrears with their contributions shall only be required to pay that part of the contribution for which they are liable as employers, and in such cases, compulsorily insured persons are required to

pay their own share of the contribution themselves. On the other hand, the employers of persons who join a substitute fund of their own free will must pay the insured, at the same time as their wages, that part of the contribution calculated as if the insured had not joined a substitute fund. The insured themselves thus become liable for the payment of the contribution due to the insurance institution.

In *Great Britain* employers are liable for the payment of contributions; and, as we shall see below, payment is effected by affixing stamps to an insurance card. In the event of the insured omitting to hand in his card in due time, the employer is responsible for obtaining a fresh card from the Post Office authorities. Stamps should as a rule be affixed on pay day, and the amount of the workers' contribution is deducted from his wages.

In *Hungary* employers are liable for the payment of the entire contribution, and are empowered to deduct the part for which the insured is liable from the latter's wages. In the event of an employer failing to pay contributions when they fall due four times in succession, and should it prove impossible to recover the debt by administrative action owing to his insolvency, he may be forbidden to deduct the insured's contribution from wages, in which case the employer ceases to be liable except for his own contributions. The insured are then required to pay their contributions directly to the sickness insurance fund concerned.

In the *Irish Free State* and in *Northern Ireland* the provisions are the same as in *Great Britain*.

In *Italy* (new provinces) employers are liable for the payment of both contributions to the insurance fund, and any agreement to the contrary is *ipso facto* null and void.

In *Japan* employers are responsible for paying the contributions of persons employed by them and are empowered to deduct the amount of workers' contributions from their wages.

In *Latvia* members' contributions are deducted from their wages by employers, who are responsible for paying them to the sickness insurance fund during the following week. Employers are required to pay their own contributions at the same time, together with the additional contribution for medical attendance, in the event of that being due.

In *Lithuania* similar provisions exist.

In *Luxemburg* employers are required to pay the entire contribution (for employers and workers) at the dates specified in the rules, the interval between which must not exceed one month. Employers are entitled to deduct that portion of the contribution for which the insured are liable from their wages on pay day. The amount deducted each time must correspond exactly to that part of the contribution which is payable in respect of the period for which the wages were due.

In *Norway* employers are empowered to deduct that portion of the premium for which the wage-earner is liable every pay day. An employer who omits to deduct this amount is liable for the payment of that fraction of the wage-earner's premium, and cannot apply to the latter for refund after he has left his service, or if more than three months have elapsed since the payment of the wages in question.

In *Poland* employers are liable for the payment of the entire contribution. That portion of the contribution for which compulsorily insured persons are liable must be deducted by the employer from the wages due for the corresponding period.

In *Roumania* (former Kingdom and Bessarabia), although no employers' contribution exists, the entire charge being borne by the workers, the system of deduction at source is nevertheless applied, and employers are entitled to deduct the insured's contributions from their wages. The system of deduction at the source is also applied in *Bukovina* and probably also in *Ardeal*.

In *Russia* instructions issued by the Commissary of Labour on 28 July 1926 provide that employers (who are solely liable for the payment of contributions) shall furnish a statement (in two copies) of the social insurance contributions paid every month, indicating the number of wage-earners employed together with the amount of their wages. This statement must be verified by the works committee (representing the trade union), and transmitted, on the fifth of

every month, to the competent social insurance institution responsible for determining the amount of contributions payable by the undertaking. The employer and the credit institution authorised for the purpose (in this case the State Bank) are then notified, and the employer must pay the amount due to the State Bank within three days of the receipt of this notice and not later than on the eleventh of the month.

In the *Serb-Croat-Slovene Kingdom* employers are liable for the payment of the entire contribution, but are empowered to deduct that portion for which the insured are liable from their wages. In the event of an employer omitting to deduct the premiums payable by a worker on the first pay day following the date when the premium became payable, he is not empowered to deduct them subsequently if more than a month has elapsed since the wages in question were paid, or more than two months if the insured is paid monthly. In the event of the employer omitting to pay the contributions due on two consecutive occasions, similar provisions apply to those which exist in Hungary.

In *Switzerland*, as already stated, the system of deduction at the source is not generally practised. In the Canton of *St. Gall*, however, employers are required by law to "see that" compulsorily insured persons pay their contributions, without imposing any liability on them. Similar provisions exist in the Canton of *Appenzell (Outer Rhodes)*. Conversely the system of deduction at the source is applied by law in *Appenzell (Inner Rhodes)*, where employers are liable for paying the contributions of compulsorily insured persons to public insurance funds, and are empowered to deduct the amount from their wages for this purpose.

THE DISCHARGE OF THE OBLIGATION

Several recognised ways exist of discharging the obligation to pay contributions when they fall due, including payment in cash, by cheque, or through a post office, and are all found in connection with the payment of social insurance contributions. Payment in cash, however, involves the transfer of large sums at comparatively short intervals, while, on the other hand, if premiums or contributions have to be "collected" this necessitates the employment of collectors, thus appreciably increasing the general cost of insurance. If they are "payable at the premises" an additional burden is imposed on contributors. Payment by cheque is still far from general in many countries. Many insurance laws therefore show a preference for payment through the post office.

To facilitate matters for contributors, to simplify the accountancy of the funds, and to reduce the cost of recovery to a minimum, a special system of paying contributions has been devised in connection with social insurance, which consists in affixing stamps, which can be purchased in advance at various offices, to a card delivered to the contributor at stated intervals. The card, after insurance stamps to the required value have been affixed, is transmitted to the competent authorities, and this constitutes a receipt for payment. The procedure has the disadvantage, it is true, if the insurance system is administered by a considerable number of financially autonomous funds, of preventing any direct contact

between debtor and creditor: since the receipts from the sale of the stamps are centralised in a special fund, and afterwards distributed among the various insurance institutions proportionately to the value of the stamps affixed to the various cards distributed to their members. A disparity may also exist, at any given moment, between the amounts actually collected for contributions and the sums payable in respect of insurance at the same date. But these disadvantages are comparatively negligible, and the use of insurance stamps is so convenient for employers, so easily checked, so clear and simple as regards accountancy, and, lastly, so economical to administer, that some surprise may be felt that it has not been more widely adopted.

In *Austria* monthly lists of contributions are drawn up by insurance funds and are submitted to the employer. Unless an objection is made by the latter within the period specified in the rules the contributions figuring on the list become payable. Contributions are regarded as public taxes, and may be recovered in the same way as direct taxes.

In *Bulgaria* contributions can be paid by purchasing insurance stamps, which are affixed to the wage-earner's insurance book. There are two kinds of stamps (1) those for sickness, maternity, invalidity, and old-age insurance, which are affixed to the insurance books of employees and workers of Bulgarian nationality and to the books of workers of foreign nationality belonging to a State with which a reciprocity treaty has been concluded, (2) stamps for sickness and maternity insurance only, which are affixed to the insurance books of foreign workers, if the reciprocity concluded with the State to which they belong only applies to these branches of insurance.

Stamps are printed by the insurance administration and distributed, through the National Bank of Bulgaria, to the Agricultural Bank, to the various popular banks, and to post offices and telegraph offices.

The Agricultural Bank, the popular and other banks, and the post offices and telegraph offices are responsible for transmitting the amounts derived from the sale of these stamps to the National Bank of Bulgaria at the end of each month.

In *Chile* contributions are paid by affixing stamps to insurance books issued by institutions to their members.

In *Czechoslovakia* there is no special method provided by law for the payment of contributions due.

Insurance contributions may be recovered by process of law on the evidence of an enforceable order to pay. Orders to pay become enforceable when a fortnight has elapsed from the date on which they were served, and the sickness insurance institution must furnish the necessary documentary evidence that the order to pay is enforceable.

In *Estonia* there are no details in the Act concerning the system of collecting contributions, and contributions which are in arrears can be recovered in the same way as taxes, or other duties, the liability for which cannot be disputed. The employer must pay interest at 1 per cent. per month (12 per cent. per annum) on contributions in arrear.

In *France* (Alsace-Lorraine) the total contribution due is paid by the employer in cash at the dates specified in the rules of the fund.

In *Germany* insurance funds are empowered to establish paying offices to which contributions must be paid by employers. The insurance office is empowered at the request of the insurance funds concerned, to designate a common registration office as a paying office.

In *Great Britain* contributions are paid by affixing stamps to the contributor's insurance card, these are delivered, valid for six months, by approved societies to their members. Members who are wage-earners are required to deposit their cards with their employer, who is responsible for affixing insurance stamps

when paying wages. A single insurance stamp represents the total amount of the employer's and worker's contribution. Insurance cards must be returned to their holders at the end of the half-year, and then sent to the society; they are then transmitted to the central department after verification, the society being credited, as stated above, with the sum due to it by transfer in the "Stamps Sold Account." A similar method is adopted in the *Irish Free State* and in *Northern Ireland*.

In *Hungary* insurance contributions must be paid to the Post Office Savings Bank. They can be recovered by administrative process in the same way as ordinary taxes.

In *Latvia* there are no special provisions relating to the payment of contributions. Those which are in arrears can be recovered in the same way as taxes, or other sums due to the State, liability for which cannot be disputed.

In *Lithuania* there are no special provisions relating to the system for recovering contributions, and unpaid contributions can be recovered in the same way as ordinary taxes.

In *Luxemburg* contributions must be paid to the competent insurance fund at the dates provided for in the rules.

In *Norway* contributions must be paid either directly to the manager of the insurance fund or to any other person authorised to receive payment.

In *Poland* employers are required to pay contributions due from insured persons in their employ, or to transmit them at their own expense; an insurance fund may, however, employ its own collectors to collect contributions.

Contributions in arrears, together with any other sums due to the fund, can be recovered in the same way as communal taxes. But insurance funds are also empowered to recover contributions in arrears by legal process; they can also resort to compulsion for this purpose by producing a duly authentic list of contributions in arrears, which can be treated, under the Act, as a judicial order.

An insurance fund may require employers to advance an amount corresponding to the total contributions payable for the quarter

- (a) if they are of foreign nationality and are not owners of any fixed business premises situated within the administrative district of the fund;
- (b) if they are more than six months in arrears with the payment of their contributions;
- (c) if they are not owners of a principal place of business in Poland, or of any other fixed business premises within the administrative district of the fund.

In *Roumania* contributions are collected by affixing stamps in the territory of the former Kingdom and in Bessarabia. Contributions which have not been paid when they are due by affixing stamps can be recovered in the same way as State taxes.

In *Russia* the method of paying contributions by the employer has already been described.

In the *Serb-Croat-Slovene Kingdom* payment of contributions is effected at the end of every month on receipt of an order for payment from the insurance institution, as provided for by the rules of the *Suzor* (Central Workers' Insurance Institution).

Contributions must be paid into the fund of the insurance institution; but the managing committee of the latter is empowered to have the contributions collected by its agents, or through the post office.

Orders for payment issued by the insurance institution must be regarded as equivalent to judicial orders. All sums due to the *Suzor* and its local representatives can be recovered by administrative process in the same way as State taxes, the sums claimed may also be recovered through the authorised representatives of the *Suzor*.

In *Switzerland* no special provisions regarding the payment of contributions appear to exist except in the Canton of *Basle Town*. In this case it is laid down that premiums or contributions are payable, when they fall due each month, by the insured at the offices of the insurance institution, or at one of its branches.

Executive decisions taken by the Department of Public Health, or one of the superior administrative authorities, relating to the payment of contribu-

tions or premiums by persons liable to compulsory insurance, are assimilated to a judicial order, as provided for in section 80 of the Federal Act concerning the recovery of debts and bankruptcy.

§ 2. — Investment of the Funds of Insurance Institutions

PRELIMINARY REMARKS

The financial working of a social insurance fund manifests itself, as in other institutions, by a perpetual change in its assets and liabilities, and a practically continuous twofold movement of receipts and disbursements. Sound financial administration is generally secured by regulating the various operations with regard to the following factors: the dates on which bills payable and receivable fall due, and the present and future movement of the credit balances. The fund constituted for the purpose of maintaining a proper financial equilibrium and damping out irregularities is usually known as the working capital or reserve against current liabilities (*fonds de roulement*). It is obvious that a fund of this kind must consist either of cash balances or of credits which can be realised at sight to their full nominal amount, such as a current account at a bank. Interest, though at a low rate, is moreover usually payable on current accounts, which therefore constitute a first form of investing any available surplus. Insurance funds are not always at liberty, however, to deposit all their available assets on current account; and the law frequently imposes an obligation to invest them at least partially in public savings banks ¹ or other public credit institutions. Restrictions of this kind are dictated by obvious considerations of prudence, since persons responsible for the financial administration of insurance funds might otherwise be tempted to invest their balances in credit institutions of doubtful financial stability. These restrictions have the additional advantage, an appreciable one for the authorities, of canalising, directly or indirectly, a regular stream of capital towards the national coffers. The law in these cases generally offers a compensation by stipulating that a higher rate of interest is payable on deposits of this character.

In the case of many sickness insurance funds that part of the

¹ A payment into a current account and a deposit in a savings bank are evidently of a different character. Nevertheless they have been assimilated here, firstly because in general the money can in either case be drawn at sight or at short notice, and secondly because in neither case does the depositor concern himself with the use to which his money is put.

assets which is not locked up in buildings and furniture rarely exceeds the margin required for maintaining the working capital at the proper figure, and the capital which does not consist of liquid balances can scarcely be distinguished from the ordinary reserve fund, in which case the two are practically identical. Consequently the only method of investment specified in some laws is to lend to the Government.

Nevertheless, the balances available during the current financial period are frequently not entirely absorbed by the maintenance of the working capital, or a relatively large surplus may be available at its conclusion. It is obvious in this case that there will be no necessity for keeping them in liquid form, and in that event there will be a tendency to use them for permanent investment, susceptible, it is true, of appreciation, but also subject to depreciation.

The legal provisions existing on this point are naturally inspired by a desire to ensure that investments of this nature can be easily realised, are safe; and yield a fairly high rate of interest. But it is difficult, if not impossible, to unite all these desiderata at the same time, and the available capital is usually invested in unequal shares which satisfy one or other of the above requirements separately, possibly at the expense of the other two.

The desire to ensure that investments can be realised without difficulty sometimes results in a restriction, or the complete prohibition, of the right to invest in real property. Restrictions or prohibitions of this kind are, moreover, justified by the fluctuations to which the yield of real property is subject, and the fact that no current market rate for this form of property exists. We shall see, however, that the prevailing views on this point have undergone considerable modification of late:

Similar arguments apply to the question of safety, a consideration formerly regarded as paramount at a time when the first legal rules on this point were adopted. These, which have in too many instances remained in force without modification from an earlier period, usually confined themselves to reproducing the provisions which, in nearly all countries, regulated and still regulate the conditions under which guardians or trustees are empowered to invest the property of their wards or of beneficiaries under the trust (trust moneys). Social insurance was at first, financially speaking, "subject to tutelage"; and it was only with obvious reluctance that legislators granted insurance institutions the right to invest a very small part of their assets otherwise than in Government securities, in securities guaranteed by the State, and on mortgage.

But ideas on this point have undergone a great change under the pressure of circumstances: on the one hand, as new forms of social insurance sprang up, and as their sphere of action grew, there was a corresponding increase in the funds available for investment, so that the danger of withdrawing the large sums thus saved out of the national income from productive purposes became increasingly apparent. On the other hand, the laws passed at various times in the interests of social progress provided, as we have already seen, new opportunities for investing available capital, yielding an income of a dual character: money interest for insurance, and social profit for the community as a whole. Lastly, the financial upheaval which post-war Europe has experienced has completely upset the calculations of the upholders of the policy of safe investment. While fully recognising the exceptional character of the crisis, it has naturally led to the adoption of less rigid views on this point, and a tendency in favour of the sums available for investment being divided and distributed on more rational lines.

Finally comes the question of the yield of the sums invested. Social insurance, even where it is organised on the basis of a system of capitalisation, is not a financial undertaking of a commercial nature: it must therefore aim in the first place at increasing its available assets by means of the interest on the sums invested. We have already explained that it is not usually desirable, under a system of distribution of costs, for the yield from investments to constitute too great a percentage of annual revenue. Where a system of capitalisation has been adopted, it will suffice if the annual yield from the amounts invested is enough to provide interest at current rates on the actuarial reserves. If the assets of an insurance institution increase faster than is required to ensure normal and regular working, this would be a drawback rather than an advantage, particularly if it only served further to enrich the institution. In this connection a policy based on a bold and far-sighted conception of the aims of social insurance is of great importance.

In the first place it will be of advantage to a general system of sickness insurance to take the necessary measures to secure hospital treatment and medical attendance for its contributors. This will provide a first method of employing its available funds, and for this purpose co-operation with invalidity insurance institutions, with a view to providing hospitals, nursing homes, sanatoria, and other institutions of a similar character, will be found both desirable

and profitable. These investments do not, it is true, yield actual revenue; but they enable economies to be effected in the provision of sickness benefits, and facilitate a stricter supervision over the quality of benefits and over claims. The supervision of medical treatment will enable the treatment to be continued until patients are cured. This in turn should tend to diminish the number of cases of intermittent sickness, involving the payment of many days of sickness benefit, by which the commercial value and economic output of labour is reduced to such a marked extent. Further, the insurance system will thus find the opportunity for participating in the general expenditure of the community on hygienic and sanitary objects, which constitute a "sound" investment in the best sense of the word.

Other arguments exist in favour of this policy: insurance legislation in many countries aims at encouraging or facilitating the creation of institutions of various kinds intended to alleviate the lot of the less wealthy classes, such as cheap dwellings, gardens, and smallholdings for workers, popular credit institutions, etc., all of which stand in need of financial support. Whether from ignorance, suspicion, or fear of an insufficient return, holders of private capital are usually reluctant to invest their savings in what are known as "charitable undertakings". It is entirely proper for social insurance institutions to take an important financial share in schemes of this kind, and this would also be their justification if a somewhat larger share of the national capital than is strictly required for meeting the actual cost of insurance were eventually to fall into their hands. In the absence of a system of social insurance, the capital required to maintain undertakings of this character, which yield an undoubted social profit, would perhaps never have been saved or, if so, utilised for that purpose.

The above considerations may be summarised as follows: the liabilities of a sickness insurance fund, functioning under a system of distribution of costs, include the working capital, and one or more provident reserve funds, in addition possibly to special funds intended to finance measures for protecting public health or preventing disease. If the system of capitalisation is adopted, an actuarial reserve will also be required. The assets of the fund corresponding with these liabilities will normally consist of different kinds of securities, of varying degrees of liquidity, security, and yield, in accordance with the character of the liabilities, and of varying degrees of utility as regards the community. The system of investment adopted will be based on the degree of urgency

with which cash may be required. With regard to actuarial reserves, security and yield should as far as possible be combined¹. As for working capital, it should be as liquid as possible; this applies equally to a certain portion of the provident reserve fund, security however being the essential requisite for the main part of this reserve. After these essential requirements have been fulfilled, it may be possible somewhat to relax the rules governing investment and to allow greater freedom to those responsible for the management, while not losing sight of the endeavour to conciliate as far as possible social utility with the financial interests of the fund.

LEGAL PROVISIONS

The legal provisions adopted in various countries relating to the investment of funds are summarised below:

In *Austria* assets can only be invested:

- (a) in trustee securities, as provided by law,
- (b) in mortgages suitable for the investment of trust money;
- (c) in post office or other public savings banks.

The working capital, which must be sufficient to meet average requirements for four months, can be placed on current account with trustworthy credit institutions. Buildings may be acquired with the approval of the supervisory authorities, provided the charges thereon are not more than half the purchase price, and that they are utilised as office premises for the funds, or to provide nursing or rest homes for contributors.

In *Belgium* (seamen's insurance) assets must be invested in Belgian *rentes*. Only the amount required to meet the estimated liabilities for a single quarter may be retained in the form of cash balances, converted into Treasury bonds, or securities payable to bearer.

In *Bulgaria* the Superior Council of Labour and Social Insurance is required, at its annual general meeting, to draw up a plan for investing the assets of social insurance funds. The money available for this purpose can only be invested by the management in accordance with the advice of the Superior Council, and in conformity with the objects specified in the Act, in other words, for the purpose of lowering the average rate of morbidity of the insured, and increasing their working efficiency.

In *Czechoslovakia* assets may be invested:

- (a) in national securities in which the investment of orphans' property is authorised, or in loans on such securities;
- (b) in bonds (productive loans) of the State, provinces, counties, districts, or communes, or any loans guaranteed by these authorities,

¹When a fund is organised on the system of capitalisation no necessity usually exists for even partially realising the actuarial reserves, so long as the insurance group continues to renew itself. Current liabilities can be met out of annual income, such as premiums and interest on capital. A need for realising the reserves, even partially, will only arise if the insurance group fails to renew itself.

- (c) in national mortgages specified as suitable for the investment of trust moneys;
- (d) in national financial institutions for whose total liabilities the State, province, county, district, or commune is security;
- (e) in bonds (productive loans) of public bodies entitled to levy taxes

At least 20 per cent. of the free moneys of insurance institutions (i.e. moneys available for permanent investment) must be invested in Czechoslovak national securities, and at least 10 per cent. in other securities specified by the Minister of Social Welfare.

The moneys necessary for current expenses may be deposited with trustworthy Czechoslovak credit institutions

An insurance institution may, subject to the approval of the Central Institution, acquire real property (buildings), provided the charges thereon are not more than half the purchase price and that it is used for the establishment of offices for the institution, or for purposes of treatment.

The Central Institution may, in individual cases, grant permission for the investment of not more than one-quarter of the free money of a sickness insurance institution in a different way, especially for the encouragement of the provision of dwellings and the promotion of social institutions exclusively or mainly for the benefit of insured persons.

In *Esthonia* all assets which are not earmarked for meeting current liabilities must be invested as follows.

- (a) in Government securities or securities enjoying a State guarantee, in mortgages registered by mortgage banks, in bonds issued by urban credit societies, or in municipal loans. The Workers' Insurance Council is empowered to specify the bonds or municipal loans which may be acquired.
- (b) On deposit or on current account with the Bank of Esthonia or with a private bank.

In *France (Alsace-Lorraine)* assets must be invested in trustee securities, in securities designated for this purpose by local laws, or in bearer securities issued by mortgage banks.

The supreme administrative authorities are also empowered to permit investment in the form of loans to communes or communal unions, even if this form of investment cannot be regarded as a trustee security.

French Government securities were substituted for German ones by the Circulars and Instructions of 20 December 1919, 5 January 1921, and 24 February 1923

Loans on first mortgage, up to 50 per cent. of the value of the mortgaged property, provided the buildings are situated in French territory, are also authorised by these Circulars. French Government securities, securities guaranteed by the Treasury, bonds issued by French Departments, communes, Colonies, or Protectorates, bonds issued by *Monts de Piété* (Government pawnbroking establishments), public savings banks in Alsace and Lorraine, the Deposit and Loan Fund of Alsace and Lorraine, and Alsace and Lorraine Government securities, are also designated as suitable for investment.

In *France* (seamen's insurance) the assets of the Provident Fund must be invested in Government securities in Treasury bonds, or in bonds enjoying a State guarantee. Exceptionally, and provided the reserves exceed the average expenditure for the past three years, funds are permitted to invest a comparatively restricted portion of their assets on mortgage, provided that the amount on loan is repayable on demand or is subject to a proper scheme of redemption, funds are also entitled to invest not more than one-fifth of their reserves in bonds issued by societies for the erection of cheap dwellings, or fully paid up shares of mortgage banks.

In *France* (miners' insurance) that part of the available balance which is not retained by the fund itself must be invested with the Deposit and Loan Fund, by which it is employed on the same conditions as moneys belonging to public savings banks at $4\frac{1}{2}$ per cent interest per annum.

In *Germany* insurance institutions were formerly only authorised to invest

their assets in securities designated for the investment of trust moneys, such as German Government securities, securities issued by the various States, or securities the interest on which was guaranteed by the Reich or by one of the individual States. The rules on this point are now less strict, with a view to enabling insurance institutions to obtain a higher yield from their investments. Investment in ordinary shares is still prohibited, but insurance institutions are now authorised to invest in written securities redeemable within a comparatively brief period, provided that the interest is adequately secured. Funds may also be invested in real property, in loans for public utility undertakings, or in the form of direct participation in undertakings of this character. Funds temporarily available may also be invested in other ways with the permission of the Federal Minister of Labour.

In *Great Britain*, as already stated, part of the assets are handed over to the approved societies, which are responsible for their investment, while the remainder is retained by the National Fund and invested by the National Debt Commissioners on behalf of each society. The portion of the funds for which the society is responsible must be invested in trustee securities or in loans to local authorities.

A similar system prevails in the *Irish Free State* and in *Northern Ireland*.

In *Latvia* the assets which are not required for meeting current liabilities must be deposited with the State Bank.

In *Lithuania* the reserve capital must be deposited with the Bank of Lithuania, or any other financial institution designed for that purpose by the Superior Social Insurance Office.

The reserve capital may also, with the approval of the general meeting and the Superior Council, be invested in securities or Government loans.

The law only authorises insurance funds to acquire real property with the consent and approval of the Superior Council of Social Insurance.

In *Luxemburg* funds are empowered to invest their assets, without restriction or limitation, either with public savings banks at a rate of interest fixed by the State, or in Public Debt securities, or in bonds issued by the *Crédit Foncier de Luxembourg*, or in communal bonds, or in Government or communal loans. Funds are also empowered, subject to Government approval, to acquire foreign Government securities or bonds issued by foreign municipalities, or to make other investments not exceeding one-half of their assets in the form of mortgages, real property, and cheap dwellings. The assets of insurance institutions should be devoted preferably to the maintenance of institutions and organisations established in the Grand Duchy for the welfare of the insured.

In *Norway* the reserves of district sickness insurance funds must as far as possible be invested within the commune itself.

So long as the reserve fund remains for three years at least equal to the average six-monthly amount paid in premiums during that period, or, if at the conclusion of the financial year the reserves are equal to the premiums paid during that period, the committee of the fund is empowered, with the approval of the Insurance Office, to invest any available surplus in schemes for the care of the sick, for instance, in the erection or upkeep of hospitals, maternity homes, tuberculosis sanatoria, etc.

When the State equalisation fund (see previous Chapter) has attained the amount specified by law, any surplus may be partially devoted to the objects specified above in each area, proportionately to the number of persons insured therein during the past year.

In *Roumania* (former Kingdom and Bessarabia), the Central Insurance Office is responsible for the financial administration of the funds of sickness insurance institutions. Assets must be invested in Government loans or securities, or in other securities enjoying a State guarantee. One-quarter of the assets may be invested in institutions or undertakings of use to the insured.

In *Russia* the assets of district and departmental funds must be invested with credit institutions designated for that purpose by the Commissariat of Finance. At present at the State Bank that part of the moneys placed on current account bears interest at a special rate (1 per cent higher than that on ordinary current accounts in the State Bank). In addition, no commission (except charges for telegrams) is levied by the State Bank in connection with other investments or ordinary banking operations.

The Direction of the Social Insurance Department was recently instructed by the Government to invest 30,000,000 roubles in cheap dwellings for workers; this sum was to be invested at $\frac{1}{2}$ per cent. interest for a period of 20 years, redemption to commence in 1929.

In virtue of a Decree, dated 12 January 1927, a deduction of $\frac{1}{2}$ per cent. of wages is made from insurance resources for the purpose of financing workers' housing schemes. With the same object contributions have been raised by 1 per cent. of wages.

In the *Serb-Croat-Slovene Kingdom*, section 135 (2) of the Act provides that the constitution of the Central Workers' Insurance Institution shall enact rules for investing the assets of the Central Institution, or of the district organisations. These are found in Article 237 of the rules of the Fund, which provide that half the reserves must be placed on current account with credit institutions of the highest class. The other half may be placed on mortgage or in bonds, in such a way as to ensure that the latter are sufficiently liquid, and yield an adequate rate of interest.

In *Switzerland* (Canton of Appenzell, Outer Rhodes) the assets must be invested in "safe" securities, selected for the purpose by the communal council.

§ 3. — Tables Showing the Value and the Composition of the Assets of Insurance Institutions

The following tables are based on the available information and give details regarding the aggregate amount and, where this information exists, the composition of the property of sickness insurance institutions.

No adequate information regarding the following countries was available: Chile, Esthonia, France (seamen's insurance), Greece, Irish Free State and Northern Ireland, Italy (new provinces), Japan, Latvia, Norway, Poland, Russia, Serb-Croat-Slovene Kingdom, Switzerland (Cantons of Appenzell (Inner and Outer Rhodes), Basle Town, and St. Gall).

AUSTRIA

Years	Total assets	Total assets per insured
1919	84,905,964 cr.	113 cr.
1920	227,038,832 "	234 "
1921	1,897,884,875 "	1,724 "
1922	62,084,121,510 "	51,440 "
1923	221,885,157,698 "	193,616 "
1924	422,545,394,812 "	338,353 "
- 1925	52,136,741 sch.	42.49 sch.

ACCOUNTANCY VALUE OF REAL PROPERTY BELONGING TO INSURANCE FUNDS

1919	4,734,459 cr.	1923	13,759,820,274 cr.
1920	7,644,905 „	1924	37,356,867,259 „
1921	38,411,007 „	1925	7,287,439 sch
1922	98,587,027 „		

The balance sheet of all the sickness insurance funds, on 31 December 1925, is reproduced below by way of illustration.

BALANCE SHEET OF ALL THE SICKNESS INSURANCE FUNDS ON 31 DECEMBER 1925
(IN SCHILLINGS)

Assets	Schillings	Liabilities	Schillings
Cash in hand	2,626,896	Loans	892,910
Bills	386,601	Debts to	
Loans on mortgage	788,405	Doctors	1,528,364
Real property	7,342,731	Insured	880,672
Deposits with savings banks	16,441,581	Medicines	1,154,899
Overdue contributions	18,685,949	Hospitals	1,550,714
Stock	1,068,651	Other unpaid creditors	706,474
Other assets	4,795,817	Liabilities on real property still unpaid	55,292
		Miscellaneous unpaid liabilities	14,971,424

CZECHOSLOVAKIA

DETAILS OF THE ASSETS

(a) Total assets (in thousands of Czechoslovak crowns). (b) Percentage of total assets.

Description of the assets	1920		1921		1922		1923	
	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
Cash in hand	17,322	13.4	26,663	9.2	19,205	5.1	15,823	3.6
Securities	26,366	20.4	33,253	11.5	39,635	10.6	49,520	11.3
Sums on deposit with banks and savings banks	37,872	29.4	103,081	35.6	122,301	32.8	130,158	29.7
Real property	14,090	10.9	23,213	8.0	63,797	17.1	98,298	22.4
Loans on mortgage	2,390	1.9	4,224	1.4	5,264	1.4	6,301	1.4
Creditors	28,032	21.7	93,800	32.4	109,504	29.3	119,497	27.2
Stock	2,908	2.3	5,601	1.9	13,840	3.7	19,122	4.4
Total	128,980	100.0	289,835	100.0	373,546	100.0	438,719	100.0

FRANCE (Alsace-Lorraine)**I. BALANCE SHEET SHOWING ASSETS AND LIABILITIES**

Year	Total assets		Total liabilities		Surplus		Surplus per insured	
	Fr	Mk.	Fr	Mk.	Fr.	Mk.	Fr.	Mk.
1919	13,116,121	11,495,487	2,235,668	1,138,130	10,880,453	10,357,357	31.87	30.34
1920	27,286,326	11,703,686	1,833,420	1,174,125	25,452,906	10,529,557	66.06	27.33
1921	40,777,605	12,118,028	2,583,913	1,066,777	38,193,692	11,051,251	97.69	28.27
1922	49,970,158	7,428,053	4,615,323	281,043	45,354,835	7,147,010	109.96	17.29
1923	57,147,965	—	5,634,414	—	51,513,551	—	117.33	—
1924	—	—	—	—	—	—	—	—
1925	—	—	—	—	—	—	—	—

II. DETAILS OF ASSETS

		1919	1920	1921	1922	1923
1. Cash in hand	{ Fr. Mk.	2,840,532 932	5,260,945 —	4,384,744 900	3,664,510 38,943	4,456,847 —
2. Loans on mortgage	{ Fr. Mk.	10,394 150,000	4,391 155,736	8,563 —	418,696 —	595,035 —
3. Negotiable securities	{ Fr. Mk.	3,731,332 10,309,254	12,508,222 10,128,981	22,204,350 10,554,679	26,846,321 5,996,887	30,921,598 —
4. Deposits in banks and savings banks	{ Fr. Mk.	4,524,043 176,175	6,735,520 307,213	9,407,737 459,053	9,853,281 637,085	10,497,032 —
5. Real property	Fr.	1,604,285	2,155,294	2,565,133	2,805,558	2,994,802
6. Furniture and fittings	Fr.	234,380	370,948	510,999	747,739	846,435
7. Creditors	{ Fr. Mk.	171,155 859,126	251,006 1,111,756	1,666,079 1,103,096	5,634,053 755,138	6,836,216 —

GERMANY**I. BALANCE SHEET SHOWING ASSETS AND LIABILITIES (IN MILLIONS OF MARKS)**

Year	Assets	Liabilities	Property of funds	
			Total	Figures per insured (in marks)
1914	413,059	27,102	386,000	24.7
1919	175,116	13,958	161,200	10.2
1924	251,999	13,626	238,400	13.8
1925	346,975	26,466	320,500	17.6

The total property of sickness insurance funds (that is, the excess of assets over liabilities) amounted in 1925 to 320,500,000 marks, as against 386,000,000 marks in 1914, so that, in spite of the fact that important investments have been made, there was a decrease of 17 per cent. as compared with 1914. If

the number of insured is taken into account, the decrease is still more noticeable, for the figure of property per insured was only 17.6 marks in 1925 as against 24.70 marks in 1914, a decrease of 30 per cent.

II. DETAILS OF ASSETS (IN THOUSANDS OF MARKS)

Description of the assets	1914	1924	1925
Cash in hand	32,998	68,479	83,141
Loans on mortgage	37,174	13,081	19,889
Negotiable securities	185,280	11,885	16,493
Sums on deposit with banks and savings banks	110,464	63,954	88,525
Real property	37,564	64,673	88,755
Fixtures and fittings	5,534	10,189	13,948
Creditors	4,045	17,998	33,816
Miscellaneous	—	1,740	2,398
Total assets	413,059	251,999	346,975

GREAT BRITAIN

The estimated value of the assets of the societies, firstly as at 31 December 1918, and secondly as at 31 December 1922 for same societies and as at 31 December 1923 for the others is shown below. (For further details regarding these valuations, see § 4 of this Chapter.) The tables published in the reports of the British Government Actuary naturally include the amounts figuring as "reserve values" among the assets; in this case, however, they have been excluded, on the ground that the present statistics aim at giving an estimate of the existing property of social insurance institutions

FUNDS OF APPROVED SOCIETIES AT VALUATION DATES (IN THOUSANDS OF POUNDS)

	First valuation, 31 December 1918	Second valuation, 31 December 1922- 1923
Invested with the National Debt Commissioners	37,726	50,615
Societies' assets		
Mortgages and loans	262	3,100
British Government securities	14,682	33,656
Other investments	1,693	2,871
Cash in hand, etc.	1,098	2,018
Total	55,461	92,260

Allowing for the fact that the total assets, estimated in 1918 at £55,500,000, must be reduced to approximately £54,000,000 as a result of subsequent transfers to the Irish Free State account, it will be seen that assets increased between the two valuation dates by approximately £38,250,000, representing an average annual increase of approximately 13 per cent, allowing for an interval of $4\frac{1}{2}$ years between the two valuation dates.

HUNGARY

PROPERTY BELONGING TO SICKNESS INSURANCE INSTITUTIONS

(1) *Total Figures of Property*

The balance sheet issued by the sickness insurance funds affiliated to the National Workers' Insurance Fund show that their property amounted in 1913 and 1914, and during the years from 1919 to 1924, to the following (in paper crowns):

1913	33,887,272	1921	277,743,853
1914	34,740,066	1922	908,053,211
1919	79,759,505	1923	15,641,838,232
1920	161,572,400	1924	154,171,359,644

(2) *Property per Insured (in paper crowns)*

1913	—	1921	463
1914	56	1922	1,327
1919	142	1923	22,060
1920	317	1924	205,920

No information regarding the invested capital, or its distribution according to the nature of the investment, is available.

The accountancy value (in paper crowns) of the buildings owned by sickness insurance funds is shown in the following table:

1913	276,282	1921	899,287
1914	332,247	1922	902,504
1919	311,820	1923	1,521,209
1920	546,567	1924	177,922,287

LUXEMBURG

I. BALANCE SHEET SHOWING ASSETS AND LIABILITIES (DISTRICT FUNDS AND WORKS FUNDS) (IN FRANCS)

Year	Total assets	Total liabilities	Surplus	Surplus per insured
1913	1,887,452	51,553	1,835,899	42.24
1919	2,285,388	160,953	2,124,435	57.15
1920	2,637,939	69,609	2,568,330	67.75
1921	2,890,197	342,887	2,547,310	67.32
1922	3,215,580	159,129	3,056,451	71.05
1923	3,787,367	64,363	3,723,000	79.69

II. DETAILS OF ASSETS (DISTRICT FUNDS AND WORKS FUNDS) (IN FRANCS)

	1913	1919	1920	1921	1922	1923
Cash in hand at the end of the financial period	162,067	536,563	799,857	850,163	738,764	829,406
Securities, savings bank books, temporary investments	1,724,995	1,744,794	1,796,390	1,998,993	2,421,865	2,902,202
Creditors	390	4,031	41,691	41,041	54,950	55,758

ROUMANIA

The total property of sickness insurance funds was estimated as follows, on 31 December 1924, at.

- (1) Former Kingdom and Bessarabia. approximately 39 million lei, invested in Government loans, miscellaneous negotiable securities, hospitals, and buildings
- (2) Ardeal: 60 million lei.
- (3) Bukovina. 6,500,000 lei.

§ 4. —The Cost of Administration

It is not proposed to discuss on whom the cost of administering a system of compulsory sickness insurance actually falls, since the chief legislative provisions relating to this aspect of the problem have already been referred to in Chapter I. But whether such costs are recovered, either wholly or partially, from the contributions themselves, or whether they are paid by employers or by the public authorities, the fact remains that they have to be met, and any attempt to estimate the efficiency of insurance must take the relative importance of this factor into account.

Before attacking the problem one may briefly recall the reasons why a system of compulsory social insurance must, generally speaking, attain a higher standard of efficiency in working than ordinary commercial insurance. Without again alluding to the various fiscal immunities which compulsory insurance enjoys in virtue of its public character, the following are generally held to be the principal financial advantages from which it benefits.

In the first place, there is no interest payable on capital; secondly, administrative functions (e.g. membership of boards of directors, etc.) are not usually remunerated and the persons acting in this capacity generally receive only their actual expenses, plus an allowance for time lost in connection with their ordinary professional occupations; thirdly, it is not necessary to seek out clients,

and consequently to pay insurance brokers or agents for their services in this connection, or to incur expenditure on advertising. But commissions on contracts of insurance represent a considerable proportion of the total expenses of an ordinary insurance business. Tabulating and checking the lists of persons and undertakings subject to compulsory insurance involve, it is true, the employment of a considerable staff, and the expense inherent to this may to some extent counterbalance the economies due to the absence of commissions.

These advantages, on the other hand, may be regarded as a legitimate compensation for the various financial burdens imposed on social insurance, from which ordinary commercial insurance is exempt. For it is difficult or impossible for social insurance institutions to select the risks to be covered, except to a very limited extent; further, whereas ordinary insurance companies are always at liberty to restrict their activities to the branches of insurance or the areas that are remunerative, social insurance must give its services irrespective of time and place, and they must apply to all the insurable risks under the law. This means that the system is compelled to work at a loss, perhaps permanently, in certain districts or as regards certain types of risk.

In seeking to estimate the comparative advantages and disadvantages entailed, the difficulty of arriving at any definite conclusion on theoretical grounds alone will be realised; also how misleading would be a mere comparison between social insurance contributions and premium rates in commercial insurance. It will be sufficient to remember that as regards the overhead charges of insurance (a heading which covers the various expenses other than the actual cost of benefits), the proportion of these expenses to the total expenditure should, under normal conditions, be considerably less for social than for commercial insurance.

The chief items in the cost of administering a compulsory system of sickness insurance include:

- (1) the cost of the redemption of initial installation expenses, and the upkeep and renewal of equipment (exclusive of medical equipment in the shape of dispensaries, sanatoria, etc.);
- (2) the salaries of the administrative staff (other than directors) employed by the various institutions; and the social burdens for which the latter are liable as employers in this connection;

- (3) the cost of settling claims, including that of supervising patients;
- (4) legal costs connected with the settlement of disputed claims, irrespective of the jurisdiction (special tribunals, or the ordinary courts) to which they are referred;
- (5) the cost of administering the supervisory machinery established by law.

Any theoretical estimate of these various factors would be impossible, since they are obviously dependent on many conditions which vary with the law and with the circumstances in each country; and, in particular, the cost of administration is closely bound up with the constitution and the working of the various institutions. It will suffice to indicate in this connection that the cost of administration is relatively less under a unified insurance system, but it must not be forgotten, as already pointed out, that systems of this kind are at a disadvantage for the purpose of supervising patients.

§ 5. — Financial and Actuarial Control

PRELIMINARY OBSERVATIONS

A system of social insurance, as a public service, is naturally bound to render an account of its financial management to the competent authorities. Where a unified financial system prevails, the central institution is, in general, only subject to the same financial supervision as other public bodies. Where, however, a considerable number of independent funds exist, special supervisory authorities, sometimes at several stages, are generally set up by law, and are responsible for verifying that the legal requirements have been duly complied with, for issuing instructions for the necessary corrections, and for enforcing the appropriate legal penalties should the need arise.

The supervisory authorities have three functions to fulfil. In the first place their authorisation or consent is necessary to establish the validity of the various financial operations carried out by the funds; secondly, they are responsible for verifying that the financial management is regular; and, thirdly, for centralising all the available information regarding the working of the insurance system, thus enabling a general view of the institution as a whole to be obtained, and ensuring that its stability is maintained. The latter function, generally known as "actuarial supervision", is of great importance.

As regards the first point, it will suffice to enumerate the chief measures which, though decided by the funds, can usually only become operative when the authorisation or approval of the supervisory authorities has been obtained. These include the fixing of ordinary contribution rates, when they are not uniform for the whole system; any modifications of these rates, applicable to special categories of insured persons; all measures relating to additional benefits; the financial provisions embodied in the rules of federations of funds; loans which funds may require to raise; and lastly, in a general way, all decisions involving the use of the financial resources or assets of the funds in cases which are not expressly covered by law.

In the second place, the supervision exercised by the competent authorities covers the following points: the auditing of the accounts; ascertaining whether receipts and expenditure conform to the requirements of the law or the rules; verifying whether the securities constituting the assets actually exist, and whether they belong to the categories specified by laws as appropriate for investment and are estimated at their correct value. Financial supervision or control can be exercised in three different ways: (*a*) by examining the various books and documents of account; (*b*) by investigations on the spot by agents of the supervisory authorities; and (*c*) by the obligation for the funds to furnish at regular intervals financial and statistical statements of account to the competent authorities.

Financial supervision naturally requires actuarial control as its complement, and whatever system of management is adopted, the central administrative authorities are obviously responsible for collecting and interpreting the information placed at their disposal and forming a correct and accurate estimate of the financial position of the various individual institutions and of the system as a whole. Any changes in rates will obviously be based on information so obtained, and so will measures intended to counteract deficits. Investigations of this kind will also show whether any changes in the law are necessary, and, conversely, if several different schemes of reform are proposed, will enable some estimate of the extent and nature of their financial effects to be formed. A law which sets up one or more branches of social insurance is necessarily a complex and comprehensive experiment; and its working must be controlled and, if necessary, progressively remedied in the light of practical experience. The central authority is therefore responsible for noting the results of the working of the system as a whole and keeping the information up to date. Moreover, this collective

experience is not of financial interest only: a study of the fluctuations in the morbidity rate, and systematic investigation, if not of their causes, at least of their correlation with various social or economic phenomena, will supply valuable information as to the general health of the population, and should also serve to reveal in what directions the insurance system can be improved and its means of action developed. There is obviously a great field here for the researches of social actuaries, and though the immediate aim is to guarantee the financial stability of the system, the scope of the problems to be examined and their connection with all the social phenomena investigated will necessarily extend beyond these immediate aims.

LEGAL PROVISIONS

The chief legal provisions relating to the financial and actuarial supervision of compulsory sickness insurance are summarised below, country by country.

Austria — Sickness funds are subject to financial supervision which is exercised in the first place by the governor of the province, who is empowered to issue instructions determining the manner in which funds shall keep their accounts. A statement of the accounts of the funds must be submitted annually to the supervisory authorities.

In case of omission by the responsible authorities of a sickness fund to make the necessary alterations in contribution or benefit rates, the supervisory authorities responsible for approving the rules are empowered to issue instructions to ensure that the necessary decision in this respect shall be taken. In the event of failure to comply with these instructions, the supervisory authorities then have legal power to make the necessary amendments in the rules.

All sickness funds are required to submit a statement of contributions levied and benefits granted to the supervisory authorities at the time stipulated and in the required form and a statement showing the amount of reserves and the manner in which they are invested. All statements and vouchers are transmitted to the Minister of Social Administration and laid annually before Parliament.

Belgium (seamen's insurance) — All books and documents of account relating to the administration of the fund must be submitted to an administrative committee appointed by the King, and all members of the committee have access to these documents. The administrative committee is responsible for submitting a statement showing the financial position of the fund, and indicating the expenditure under the head of pensions, benefits, etc., every quarter to the competent Minister. The annual accounts of the fund are published in *Le Moniteur*.

Bulgaria. — The budget of the social insurance fund is voted by the National Assembly and administered in conformity with the legal provisions relating to the budget, to accounts, and to undertakings.

The budget of the fund is examined by the Superior Council of Labour and Social Insurance before it is submitted to the National Assembly.

The application of the financial provisions adopted by the Assembly is controlled by a special Supervisory Department consisting of a controller-general and a controller for each separate account of receipts and expenditure.

The accounts of the fund are verified annually immediately after the termination of the financial year by a commission appointed for that purpose by the

Minister of Commerce, Industry, and Labour, consisting of representatives of the Ministry of Commerce, Industry and Labour, the Ministry of Finance, the Court of Accounts, the National Bank of Bulgaria, and the Chamber of Commerce and Labour. This commission is responsible for drawing up a statement showing the financial position of the fund, which is then submitted to the Minister of Commerce, Industry and Labour for his approval.

Czechoslovakia — The Central Institution is responsible for the supervision of the financial stability of funds, in other words, supervision is carried out by an independent central body and applies to independent institutions of an inferior category.

The Central Institution is empowered, for purposes of supervision, to require that all books and documents of account shall be submitted to the persons appointed by it for that purpose, together with all other information required for the purposes of supervision.

All sickness insurance institutions are required to submit to the Central Institution annually, at the dates and in the manner prescribed, a properly audited statement of accounts, and statistics and statements relating to membership, the number of cases of sickness and death, the number of days of sickness, the insurance contributions levied and insurance benefits granted, and, lastly, the amount of the reserves and the securities in which they are invested.

The Central Institution must, on the basis of the reports supplied by the funds, draw up a general report on the financial position of the sickness insurance system, which is then submitted annually to the Minister of Social Insurance, and the latter is also required to submit all the statements and reports concerned to the National Assembly.

Estonia — Supervision is carried out by officials of the factory inspection services who are empowered to verify the accounts of sickness funds and to supervise the financial management and the accountancy of the funds.

Both the authorities responsible for the administration of workers' insurance and the factory inspectorate are empowered to require the management of funds to render the accounts of the fund and to furnish any information that may be required relating to the membership of the fund, the number of cases of sickness and death, any additional contributions or other payments levied, the medical and other benefits in kind granted by the fund, at the dates specified and in the form prescribed by the said authorities. The reports issued by factory inspectors relating to the supervision of accounts must be submitted to the authorities responsible for the administration of workers' insurance.

France (Alsace-Lorraine) — The Insurance Office acts as the supervisory authority and is empowered to verify the accounts of all insurance institutions at any time.

The manner and form in which accounts should be kept was determined by an Order of the German Federal Council, dated 9 October 1913, amended by that of 26 May 1916. Funds are required to furnish the Insurance Office with a financial statement and tables showing.

- (1) the number of members;
- (2) the number of cases of sickness and the medical and funeral benefits granted;
- (3) the amount levied in contributions;
- (4) the cost of benefits granted;
- (5) the nature and amount of the fees paid for medical attendance and treatment;
- (6) the number of doctors, specialists, dental surgeons, dentists, owners or managers of pharmacies, and other persons engaged in the sale of medicines on behalf of the fund.

The Orders also specify the dates when and the manner in which the above information is to be furnished.

France (seamen's insurance). — Financial supervision of the provident fund is carried out, in the first place, by the Superior Commission for Disabled Seamen, and subsequently by the Ministers of Marine and Finance.

France (miners' insurance). — Supervision is exercised locally by the engineers belonging to the Department of Mines and the Prefects, while the Minister of Labour constitutes the central supervisory authority.

Germany — Funds are required to furnish the Insurance Office with statements of accounts and statements showing the membership, contributions levied, benefits granted, etc. (See above under *France*)

The manner in which accounts are to be rendered is determined by the Federal Minister of Labour.

Great Britain. — Any financial supervision strictly so called of approved societies is unnecessary in view of the financial system of health insurance in Great Britain, but their accounts are subject to Government audit (see page 672)

On the other hand, the system of capitalisation necessitates, as will be explained below frequent actuarial valuations.

The position is similar in the *Irish Free State* and in *Northern Ireland*

Japan — All insurance institutions are required to submit their budgets annually to the Department of Home Affairs for approval. The annual report and monthly reports relating to the working of the fund must also be submitted to the Director of Social Affairs. Accounts must be kept in the prescribed form.

Latvia — The factory inspectorate acts as supervisory authority. The officials belonging to this service may make investigations into the assets of funds, their financial working, and the way in which accounts are kept and presented by the management.

They are empowered to require the management of funds to furnish statements of accounts and information concerning the membership of the fund, the general health and the death rate of members, the contributions and additional contributions levied, and the money benefits and medical treatment granted by the fund, at the times specified and in the manner prescribed by the Minister of Social Welfare.

The reports concerning all enquiries carried out by a factory inspector must be submitted to the Minister.

Lithuania. — The Superior Office of Social Insurance, established by the Act of 23 March 1926, is responsible for the general supervision and control of insurance institutions and their financial stability.

Luxemburg. — The Social Insurance Office is subject to Government supervision and control which is intended to ensure proper compliance with legal provisions and the rules of the fund. The Government is empowered to supervise directly or indirectly the financial management of the Social Insurance Office. Members of managing committees and other bodies set up by the Office must submit, when required, all books of accounts, vouchers, securities, and other relevant documents relating to accounts, the grant of pensions, benefits, etc., and must supply the Government with any other information which is considered necessary for purposes of supervision.

Norway — Every fund is required, if possible, to submit its annual accounts to audit before the end of February.

The committee of the fund then submits the duly-audited accounts to the communal authorities before the end of April, and the latter make their report.

As soon as accounts have been audited, the fund must submit a statement of account to the State Insurance Office, together with the statistical data required in the form prescribed by the Office. A manuscript or printed copy of this statement must be exhibited during four weeks in a place to which the public has access.

The law provides for stricter control as regards approved private funds or communal sickness funds. In this case the statement of account for the previous financial year must be supplemented by a declaration by a public official, or by the mayor of the locality, certifying that the amounts shown in cash as savings banks deposits, and, if necessary, the values attributed to assets in the statement, are correct.

The Insurance Office is empowered, if it appears that the finances management of the fund are not being properly managed, after examination of the documents transmitted by approved private funds or communal sickness funds, to require that any irregularities shall be put right after they have been submitted to the general meeting of the fund.

The State Insurance Office is responsible for the general direction of district sickness funds and approved private funds, and funds are required to submit to its supervision.

Russia. — Each local fund includes an auditing committee appointed by the Trade Union Conference at the same time as the managing committee of the fund, and members of the latter are not entitled to sit on the auditing committee. These committees carry out their duties, either spontaneously or at the request of the superior insurance institutions, and are responsible, *inter alia*, for verifying all the accounts and supervising the financial position of the funds. They report to the departmental insurance institution (Departmental Fund or Departmental Office).

Auditing committees, similar to those described above, also exist in the departmental insurance funds, which are responsible for the supervision of local funds; and these committees report to the superior insurance institutions, i.e. to the principal social insurance institution of each Republic.

This institution is assisted by a Social Insurance Council, which takes cognisance of all the programmes and budgets, and of the general financial situation of the insurance system as a whole.

The principal direction of social insurance for the entire country is assisted by a Federal Insurance Council, with similar powers and functions.

All these bodies hold regular meetings periodically, and also hold extraordinary general meetings¹. Meetings of the Federal Insurance Council are held at least once a month.

Serb-Croat-Slovene Kingdom. — The Minister of Social Affairs is responsible for the general financial supervision of social insurance. He is empowered to prescribe the manner in which all books and other documents of account, including statistics, shall be kept by the Central Workers' Insurance Institution and its local branches.

The Central Workers' Insurance Institution, which is regarded as the sole insurance unit for accountancy purposes, is required to submit a yearly balance sheet, together with insurance statistics, before the end of each June following the conclusion of the preceding financial year.

Switzerland (Appenzell, Outer and Inner Rhodes). — The accountancy department of public insurance funds must be entirely separate from other branches of the communal administration, and accounts must be kept so that a yearly balance sheet can be established without difficulty in the form prescribed by the Federal Council. Accounts must be published after they have been audited and approved by the communal council.

ACTUARIAL VALUATIONS

Here the sole problem to be considered is that of ensuring financial stability. An examination of the annual accounts immediately shows the financial position of an insurance system operating on the basis of distribution of costs, both as regards the system as a whole and its component institutions. In theory each financial year constitutes a separate and self-sufficing unit, and the only question to be considered is whether each society or fund has succeeded in balancing its budget for the year. In fact, however, the various financial operations of the fund are never actually liquidated at the conclusion of the financial period, nor is a completely fresh start made at the commencement of the

¹ The local auditing committees appear to have performed their work somewhat irregularly, and this is emphasised in a circular issued on 3 February 1925 by the Central Trades Union Council. *Troud*, 3 Feb. 1925.

subsequent one, as would be required under a strict system of a distribution of costs. Funds own property, or should do so; and the character of their assets is naturally an important factor in forming an opinion as to their financial stability.

In what measure and to what extent have they to call upon their reserves? Is there a surplus of receipts over expenditure? What are the sums it has been possible to set aside for hygienic and preventive purposes? What estimates as regards the future financial position of the insurance system can be based on past financial periods?

All the above questions are obviously of fundamental importance. On the one hand, however, the opinion formed as regards the present financial position of funds will not be modified by the answers to these questions; while, on the other, no special financial technique is required for their solution. For this reason, the various reports dealing with the working of insurance under a system of distribution of costs do not generally include any actuarial valuations properly so called, and it is possible for the lay reader to form some opinion of the general financial position of the system by an examination of the accounts and statistics published. ✓

Where a system of capitalisation is in force, however, the position is entirely different. In this case the *present* financial equilibrium of the system depends to a great extent on how future assets and liabilities are valued and the adoption of a different basis of valuation is sufficient to change a surplus into a deficit, or vice versa. Moreover, valuation in this case involves the use of special technical methods with which only specialists are conversant. It will readily be seen, therefore, that the insurance laws applied in Great Britain, Northern Ireland, and the Irish Free State necessarily include detailed provisions concerning the special measures required in this connection.

Great Britain. — Section 74 of the National Health Act of 7 August 1924 provides that a valuation of the assets and liabilities of every approved society and every branch of an approved society shall be made by a valuer appointed by or with the approval of the Treasury at the expiration of every five years, or at such other times as the Minister may appoint (see also Royal Commission, *Evidence*, Appendix, Part I, p. 47).

The first valuation balance dealt with the position of approved societies on 31 December 1918. The technical data on which this valuation was based have already been referred to (e.g. the morbidity tables based on the working of the Manchester Unity, the mortality tables based on the experience during the years 1908-1910 in England and Wales, rate of interest at 3 per cent.) The following table shows the results of valuation in round numbers¹.

¹ *Report of the Government Actuary on the Valuations of the Assets and Liabilities of Approved Societies as at 31 December 1918*, p. 10. London: H.M. Stationery Office, 1922.

VALUATION BALANCE SHEET AS AT 31 DECEMBER 1918 (IN THOUSANDS OF POUNDS)

Present value of benefits and cost of administration	451,307	Present value of contributions	253,995
Contingencies funds	6,570	Present value of State grant	103,600
Other liabilities	3,532	Reserve values	64,018
Net surplus	17,193	Funds of approved societies	55,461
		Other assets	1,528
Total	478,602	Total	478,602

It must be remembered that the item "total funds" includes the £64,018,000 of "reserve values", resulting from an original fictitious credit of £69,600,000, of which approximately £5,000,000 had been written off on 31 December 1918.

The first valuation showed a considerable surplus.

The following table will give some idea of the nature of that surplus.

STATEMENT OF PROFITS AND LOSSES ON THE ACTUARIAL ESTIMATES ¹

Source of profit or loss ²	Profit		Loss	
	Men	Women	Men	Women
	£	£	£	£
Sickness	4,964,000	1,622,000	228,000	57,000
Disablement	3,559,000	209,000	12,000	100,000
Maternity	1,321,000	413,000	72,000	7,000
Mortality	162,000	13,000	1,206,000	619,000
Cessation of insurance	1,686,000	1,855,000	—	—
Marriage	—	666,000	—	4,000
Widowhood	—	4,000	—	52,000
Contributions	586,000		2,912,000	
Interest in excess of 3%	1,571,000		—	
Administration	200,000		—	
Interest on valuation surplus or deficiency	1,214,000		6,000	
Miscellaneous items	2,591,000		168,000	
Total	22,636,000		5,443,000	

¹ *Ibid.*, p. 17

² Benefits may constitute a profit or a loss in so far as they fall below or exceed the estimates in this connection. Mortality can be a source of profit if the rate increase, and of loss if it decrease, since the highest morbidity rate occurs in advanced age. Capitalisation may give rise to profit or loss in accordance as the interest on investments exceeds or falls below the regular rates. Contributions are a source of profit or loss in as far as average annual contributions per insured member exceed or fall below the estimated amount. Cases where insurance ceases (otherwise than owing to death) are a source of profit because they tend to increase reserves.

A detailed examination of these figures would be of great interest; but the reader may be referred to the report itself, according to which the actual surplus was attributable to war conditions. In other words, to the decreased demand for sick benefits due to the universal will to work, the decrease in the birth rate, the increased yield of investments, the high annual average

of contributions (per member) attributable to the absence of unemployment and, lastly, to the decrease in future financial burdens caused by the increased mortality due to the war.

Apart from the financial position of the system as a whole, an examination of the position in each society shows that there was a surplus in nearly every case (96 per cent. of societies showed an average surplus of £1 per member; and the remainder, approximately 4 per cent., only showed an average deficit of 5s. per member).

The surplus realised by individual societies was divided into two parts; one of these was attributed to reserves, while the other, known as the "disposable surplus" was devoted to granting increased benefits during the subsequent period. These disposable surpluses amounted to approximately £9,000,000, slightly more than half the total surplus.

The second valuation was made in respect to the position at 31 December 1922, covering 4,191 societies or branches with a membership of 3½ millions, and at 31 December 1923 covering 3,891 societies or branches with a membership of 4½ millions. The same technical data were utilised as in the preceding case¹.

The results of this valuation are shown in the following table:

VALUATION BALANCE SHEET AS AT 31 DECEMBER 1922-1923
(IN THOUSANDS OF POUNDS)

Present value of benefits and cost of administration	610,476	Present value of contributions	333,014
Contingencies funds	5,825	Present value of State grant	135,585
Other liabilities	2,894	Reserve values	97,400
Net surplus	42,322	Funds of approved societies	92,260
		Other assets	3,258
Total	661,517	Total	661,517

The "total benefit funds" shown in the above table include £97,400,000 of "reserve values" which had been estimated at £64,000,000 in the previous valuation. Various alterations which occurred before 1919, but which it was impossible to take into account in the 1918 valuation, had reduced this figure to £63,000,000. In the interval between the two valuations it became necessary to credit the societies with an additional sum of £50,500,000 owing to the increased financial burdens placed upon them by the Insurance Acts of 1920 and 1922. On the other hand, the balance between reserve values created in respect of new members and wiped off in respect of persons ceasing to be insured during the financial period in question represented a decrease of £7,500,000, and £2,500,000 of reserve values were transferred to the Irish Free State, while £6,000,000 were turned into cash; this explains how the figure of £97,500,000 is arrived at (64 + 50.5 — 1 — 7.5 — 2.5 — 6).

The surplus at the second valuation was still larger. A considerable part of it (£16,382,000 out of £42,322,000) should be attributed to the period immediately preceding 31 December 1918, when the causes to which profits were due (and which are referred to above) were still operative. The remaining profit occurred during the period between 1918 and 1922 or 1923.

The principal sources of profit, in comparison with actuarial bases, include sick benefits (approximately £11,000,000), invalidity benefits (approximately £4,000,000), and capitalisation (interest in excess of 3 per cent. estimated at approximately £6,000,000).

The above surplus was distributed between approved societies in Great Britain as follows:

¹ Report of the Government Actuary on the Second Valuation of the Assets and Liabilities of Approved Societies London, 1927

Country	Valuations showing surplus			Valuations showing deficiency		
	Number of valuations (societies and branches)	Number of members	Average surplus per member	Number of valuations (societies and branches)	Number of members	Average deficit per member
England	7,055	12,623,000	2.94	99	167,000	0.38
Scotland	530	1,582,000	2.53	8	9,500	0.42
Wales	364	560,000	1.71	21	37,000	0.45

Two difficulties arise in connection with the disposable surplus

(1) Owing to inequalities between the surpluses realised by various societies, some of the insured became entitled to large additional benefits, thus occupying a privileged position. Although inequalities of this nature are inherent in the British financial system, the Royal Commission held that they were tending to become harmful to the interests of the insured as a whole, and therefore proposed to remedy this defect by centralising half the available surpluses in the future, and distributing the available amounts between the various societies in proportion to their membership (*Report of the Royal Commission*, pp. 279-280). No legislation embodying this recommendation of the Royal Commission has so far been enacted.

(2) The aggregate available surplus was so large that it was obviously impossible to devote it entirely to granting additional benefits for a period of five years, as was done after the first valuation. Drawing up a plan of additional benefits for a period exceeding five years involved obvious administrative difficulties, however, and it was therefore decided to retain this limit; but this made it necessary to estimate the disposable surplus for that period, regard being had to the maintenance of a reasonable level of additional benefits. The present disposable surplus amounts to approximately £27,000,000.

In the *Irish Free State*, a valuation of assets and liabilities must be made every five years, and the second valuation (the first in the Irish Free State) relates to the period ending 31 December 1923. At that date 72 societies and 20 branches (all belonging to the same society) showed a surplus varying between 5s. 3d. and £3 17s. 5d. per member. 84 of these societies or branches, with a membership of 314,000, showed a surplus available for granting additional benefits varying from 18s. 6d. to £2 9s. 10d. per member. Only 7 societies, with a membership of 29,000, showed a deficit, which was estimated at 9s. per member.

In *Northern Ireland*, the law also provides for a valuation every five years, and the results of the valuation of 31 December 1923 are shown in the report for Great Britain. Out of 58 societies or branches, with a membership of 220,000, 52, with a membership of 205,000, showed an average surplus of £1.91 per member, and only six, with a membership of 15,000, an average deficit of £0.57 per member.

International Tabular Summary: Financial Resources and their Management

STATISTICS RELATING TO THE SOURCES AND AMOUNT OF REVENUE

COUNTRY	Year	Amount of contributions		Public subsidies		Interest		Total revenue including miscellaneous receipts		Contributions as percentage of total revenue	Remarks
		Total (a)	Average per insured (b)	Total (a)	Average per insured (b)	Total (a)	Average per insured (b)	Total (a)	Average per insured (b)		
AUSTRIA: ¹ General scheme (excluding agricultural workers) (a) = 1,000,000's of paper crowns (b) = paper crowns	1919	125	165.8	—	—	—	—	129	171	96.9	
	1920	457	471	—	—	—	—	472	486	96.8	
	1921	3,093	2,809	—	—	—	—	1,170	2,878	91.6	
	1922	418,683	98,306	—	—	—	—	120,867	100,146	98.2	
	1923	450,965	393,509	—	—	—	—	176,823	416,073	94.6	
	1924	812,187	650,542	—	—	—	—	869,402	696,558	94.4	
	1925	989,640	806,610	—	—	—	—	1,091,168	889,532	90.7	
Special scheme for miners (a) = 1,000,000's of paper crowns; (b) = paper crowns	1919	4.5	139.4	—	—	—	—	4.6	305.8	97.8	
	1920	14.8	373.9	—	—	—	—	13.2	310.8	97.4	
	1921	93.3	3,207.9	—	—	—	—	95.5	3,384	97.7	
	1922	4,142.2	128,615.8	—	—	—	—	4,309.2	133,800	96.1	
	1923	13,677.9	471,066	—	—	—	—	14,409.1	496,748	94.9	
	1924	20,003.7	766,172	—	—	—	—	21,925.6	839,741	94.2	
BULGARIA: ¹ (a) = 1,000's of levass; (b) = levass.	1919	1,666	48	1,000	28.80	268	7.71	3,545	102.10	47	¹ Statistics comprise revenue of accident insurance as well as of sickness insurance
	1920	2,994	48	1,000	16.03	405	6.49	4,890	78.44	61.2	
	1921	4,683	48	1,000	10.25	569	5.83	6,865	70.36	68.2	
	1922	5,397	48.09	1,000	8.91	748	6.66	7,742	68.97	69.5	
	1923	5,653	44.98	1,000	7.90	873	6.34	8,509	66.11	68	
	1924	28,686	170.94	8,000	17.67	1,523	9.08	39,400	232.99	73.4	
	1925	72,966	302.58	16,000	66.35	2,939	12.15	94,772	393.01	77	
CHILE: ¹ (a) = 1,000's of pesos, (b) = pesos.	1925-27	24,049	55,962	7,480	17.402	—	—	31,545	73.402	—	¹ The statistics, which comprise the revenue of sickness, maternity, invalidity, and old-age insurance relate to the first year's working of

CZECHOSLOVAKIA: Bohemia, Moravia and Silesia: (a) = 1,000's of crowns, (b) = crowns.	1919	140,761	92.6	—	—	—	—	—	110,761	92.6	400	the scheme. There was therefore no interest on invested funds, revenue, however, considerably exceeded expenditure. The Central Fund has given provisional instructions to insurance institutions to apply 1/2 of their revenue to the accumulation of capital to provide invalidity, old-age, and survivors' pensions, the remaining 1/2 being used to cover the cost of sickness, maternity, and funeral benefits, and of administration. ² Based on average number of insured in 1925 and 1926.
	1920	243,293	423.9	—	—	—	—	—	243,293	423.9	100	
	1921	748,131	368.6	—	—	—	—	—	748,131	368.6	100	
	1922	808,562	378.4	—	—	—	—	—	810,360	379.3	99.8	
	1923	742,064	342.2	—	—	—	—	—	743,750	343	99.8	
	1924	802,022	339.6	—	—	—	—	—	803,609	340.2	99.8	
Slovakia and Sub-Carpathian Russia: (a) = 1,000's of crowns, (b) = crowns.	1921	—	—	—	—	—	—	—	97,613	313.75	—	
	1922	—	—	—	—	—	—	—	96,548	314.58	—	
	1923	—	—	—	—	—	—	—	86,145	277.53	—	
	1924	—	—	—	—	—	—	—	90,098	273.33	—	
Special scheme for miners in Bohemia, Moravia, and Silesia: (a) = 1,000's of crowns, (b) = crowns.	1919	29,448	193.8	—	—	—	—	—	33,785	—	87.1	
	1920	39,675	234.6	—	—	—	—	—	43,870	—	90.4	
	1921	140,565	832.1	—	—	—	—	—	147,499	873.1	95.3	
	1922	128,822	840.8	—	—	—	—	—	143,062	933.7	90	
	1923	92,428	650.3	—	—	—	—	—	111,579	763	82.8	
	1924	—	—	—	—	—	—	—				
FRANCE: Alsace-Lorraine: (a) = 1,000's of francs, (b) = francs.	1919	36,917	108.14	—	—	—	—	—	37,583	110.09	98.2	
	1920	50,504	131.08	—	—	—	—	—	51,789	134.42	97.5	
	1921	67,062	171.32	—	—	—	—	—	69,390	177.48	96.6	
	1922	68,177	161.92	—	—	—	—	—	70,583	170.75	96.6	
	1923	76,589	170.79	—	—	—	—	—	78,027	177.71	96.1	
	1924	76,528	178.72	—	—	—	—	—	81,543	185.57	97	

International Tabular Summary: Financial Resources and their Management

STATISTICS RELATING TO THE SOURCES AND AMOUNT OF REVENUE (*continued*)

COUNTRY	Year	Amount of contributions		Public subsidies		Interest		Total revenue including miscellaneous receipts		REMARKS
		Total (a)	Average per insured (b)	Total (a)	Average per insured (b)	Total (a)	Average per insured (b)	Total (a)	Average per insured (b)	
FRANCE : Special scheme for miners (1) = 1,000's of francs, (b) = francs	1913	9,263	40.19	6	0.02	152	0.62	40,786	44.40	1 The total revenue has been calculated without taking into account of extraordinary receipts resulting from the sale of the property of funds, and amounting to 76,092,209 marks in 1914, 91,569,373 marks in 1924 and 120,804,300 marks in 1925. If these receipts are taken into account, the average total revenue per insured becomes 43.02 marks in 1914, 61.47 marks in 1924 and 75.96 cent in 1925, and the proportion of contributions to the total revenue falls to 78 % in 1914 and 89.6 % in 1924 and 1925. 2 In 1924 sickness funds in the general scheme and the special scheme for miners and substitute funds received a subsidy of 40,000,000 marks which was shared in proportion to their expenditure on maternity benefits. This subsidy was raised to 20,000,000 marks for 1925 and 1926.
	1920	—	—	—	—	—	—	23,961	119.16	
	1921	—	—	—	—	—	—	28,409	126.69	
	1922	—	—	—	—	—	—	30,089	125.25	
	1923	—	—	—	—	—	—	36,885	139.06	
GERMANY : General scheme (excluding substitute funds) : (a) = 1,000,000's of gold marks ; (b) = gold marks.	1914	523.8	33.4	—	—	11.7	0.75	595.31	38.14	1 The total revenue has been calculated without taking into account of extraordinary receipts resulting from the sale of the property of funds, and amounting to 76,092,209 marks in 1914, 91,569,373 marks in 1924 and 120,804,300 marks in 1925. If these receipts are taken into account, the average total revenue per insured becomes 43.02 marks in 1914, 61.47 marks in 1924 and 75.96 cent in 1925, and the proportion of contributions to the total revenue falls to 78 % in 1914 and 89.6 % in 1924 and 1925. 2 In 1924 sickness funds in the general scheme and the special scheme for miners and substitute funds received a subsidy of 40,000,000 marks which was shared in proportion to their expenditure on maternity benefits. This subsidy was raised to 20,000,000 marks for 1925 and 1926.
	1924	951.7	54.9	2	—	8.8	0.51	971.21	56.18	
	1925	1,240.5	67.8	—	—	11.1	0.61	1,264.41	69.34	
	1914	—	—	—	—	—	—	—	—	
	1924	75.4	80.01	2	—	1.4	1.44	77.6	88.50	
Special scheme for miners (a) = 1,000,000's of gold marks ; (b) = gold marks	1925	84.8	103.08	—	—	1.2	1.50	92.8	113.50	1 The total revenue has been calculated without taking into account of extraordinary receipts resulting from the sale of the property of funds, and amounting to 76,092,209 marks in 1914, 91,569,373 marks in 1924 and 120,804,300 marks in 1925. If these receipts are taken into account, the average total revenue per insured becomes 43.02 marks in 1914, 61.47 marks in 1924 and 75.96 cent in 1925, and the proportion of contributions to the total revenue falls to 78 % in 1914 and 89.6 % in 1924 and 1925. 2 In 1924 sickness funds in the general scheme and the special scheme for miners and substitute funds received a subsidy of 40,000,000 marks which was shared in proportion to their expenditure on maternity benefits. This subsidy was raised to 20,000,000 marks for 1925 and 1926.
	1914	16,797	1.23	5,737	0.12	618	0.05	23,152	1.70	
	1915	18,284	1.30	6,457	0.43	899	0.06	25,640	1.82	
	1916	17,784	1.20	5,159	0.35	1,199	0.08	24,132	1.63	
	1917	18,166	1.18	5,764	0.37	1,628	0.11	25,559	1.67	
GREAT BRITAIN : (a) = 1,000's of £, (b) = £.	1914	16,797	1.23	5,737	0.12	618	0.05	23,152	1.70	1 The total revenue has been calculated without taking into account of extraordinary receipts resulting from the sale of the property of funds, and amounting to 76,092,209 marks in 1914, 91,569,373 marks in 1924 and 120,804,300 marks in 1925. If these receipts are taken into account, the average total revenue per insured becomes 43.02 marks in 1914, 61.47 marks in 1924 and 75.96 cent in 1925, and the proportion of contributions to the total revenue falls to 78 % in 1914 and 89.6 % in 1924 and 1925. 2 In 1924 sickness funds in the general scheme and the special scheme for miners and substitute funds received a subsidy of 40,000,000 marks which was shared in proportion to their expenditure on maternity benefits. This subsidy was raised to 20,000,000 marks for 1925 and 1926.
	1915	18,284	1.30	6,457	0.43	899	0.06	25,640	1.82	
	1916	17,784	1.20	5,159	0.35	1,199	0.08	24,132	1.63	
	1917	18,166	1.18	5,764	0.37	1,628	0.11	25,559	1.67	
	1917	18,166	1.18	5,764	0.37	1,628	0.11	25,559	1.67	

	1918	1919	1920	1921	1922	1923	1924	1925	1926	1927	1928	1929	1930	1931	1932	1933	1934	1935	1936	1937	1938	1939	1940	1941	1942	1943	1944	1945	1946	1947	1948	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045	2046	2047	2048	2049	2050	2051	2052	2053	2054	2055	2056	2057	2058	2059	2060	2061	2062	2063	2064	2065	2066	2067	2068	2069	2070	2071	2072	2073	2074	2075	2076	2077	2078	2079	2080	2081	2082	2083	2084	2085	2086	2087	2088	2089	2090	2091	2092	2093	2094	2095	2096	2097	2098	2099	2100	2101	2102	2103	2104	2105	2106	2107	2108	2109	2110	2111	2112	2113	2114	2115	2116	2117	2118	2119	2120	2121	2122	2123	2124	2125	2126	2127	2128	2129	2130	2131	2132	2133	2134	2135	2136	2137	2138	2139	2140	2141	2142	2143	2144	2145	2146	2147	2148	2149	2150	2151	2152	2153	2154	2155	2156	2157	2158	2159	2160	2161	2162	2163	2164	2165	2166	2167	2168	2169	2170	2171	2172	2173	2174	2175	2176	2177	2178	2179	2180	2181	2182	2183	2184	2185	2186	2187	2188	2189	2190	2191	2192	2193	2194	2195	2196	2197	2198	2199	2200	2201	2202	2203	2204	2205	2206	2207	2208	2209	2210	2211	2212	2213	2214	2215	2216	2217	2218	2219	2220	2221	2222	2223	2224	2225	2226	2227	2228	2229	2230	2231	2232	2233	2234	2235	2236	2237	2238	2239	2240	2241	2242	2243	2244	2245	2246	2247	2248	2249	2250	2251	2252	2253	2254	2255	2256	2257	2258	2259	2260	2261	2262	2263	2264	2265	2266	2267	2268	2269	2270	2271	2272	2273	2274	2275	2276	2277	2278	2279	2280	2281	2282	2283	2284	2285	2286	2287	2288	2289	2290	2291	2292	2293	2294	2295	2296	2297	2298	2299	2300	2301	2302	2303	2304	2305	2306	2307	2308	2309	2310	2311	2312	2313	2314	2315	2316	2317	2318	2319	2320	2321	2322	2323	2324	2325	2326	2327	2328	2329	2330	2331	2332	2333	2334	2335	2336	2337	2338	2339	2340	2341	2342	2343	2344	2345	2346	2347	2348	2349	2350	2351	2352	2353	2354	2355	2356	2357	2358	2359	2360	2361	2362	2363	2364	2365	2366	2367	2368	2369	2370	2371	2372	2373	2374	2375	2376	2377	2378	2379	2380	2381	2382	2383	2384	2385	2386	2387	2388	2389	2390	2391	2392	2393	2394	2395	2396	2397	2398	2399	2400	2401	2402	2403	2404	2405	2406	2407	2408	2409	2410	2411	2412	2413	2414	2415	2416	2417	2418	2419	2420	2421	2422	2423	2424	2425	2426	2427	2428	2429	2430	2431	2432	2433	2434	2435	2436	2437	2438	2439	2440	2441	2442	2443	2444	2445	2446	2447	2448	2449	2450	2451	2452	2453	2454	2455	2456	2457	2458	2459	2460	2461	2462	2463	2464	2465	2466	2467	2468	2469	2470	2471	2472	2473	2474	2475	2476	2477	2478	2479	2480	2481	2482	2483	2484	2485	2486	2487	2488	2489	2490	2491	2492	2493	2494	2495	2496	2497	2498	2499	2500	2501	2502	2503	2504	2505	2506	2507	2508	2509	2510	2511	2512	2513	2514	2515	2516	2517	2518	2519	2520	2521	2522	2523	2524	2525	2526	2527	2528	2529	2530	2531	2532	2533	2534	2535	2536	2537	2538	2539	2540	2541	2542	2543	2544	2545	2546	2547	2548	2549	2550	2551	2552	2553	2554	2555	2556	2557	2558	2559	2560	2561	2562	2563	2564	2565	2566	2567	2568	2569	2570	2571	2572	2573	2574	2575	2576	2577	2578	2579	2580	2581	2582	2583	2584	2585	2586	2587	2588	2589	2590	2591	2592	2593	2594	2595	2596	2597	2598	2599	2600	2601	2602	2603	2604	2605	2606	2607	2608	2609	2610	2611	2612	2613	2614	2615	2616	2617	2618	2619	2620	2621	2622	2623	2624	2625	2626	2627	2628	2629	2630	2631	2632	2633	2634	2635	2636	2637	2638	2639	2640	2641	2642	2643	2644	2645	2646	2647	2648	2649	2650	2651	2652	2653	2654	2655	2656	2657	2658	2659	2660	2661	2662	2663	2664	2665	2666	2667	2668	2669	2670	2671	2672	2673	2674	2675	2676	2677	2678	2679	2680	2681	2682	2683	2684	2685	2686	2687	2688	2689	2690	2691	2692	2693	2694	2695	2696	2697	2698	2699	2700	2701	2702	2703	2704	2705	2706	2707	2708	2709	2710	2711	2712	2713	2714	2715	2716	2717	2718	2719	2720	2721	2722	2723	2724	2725	2726	2727	2728	2729	2730	2731	2732	2733	2734	2735	2736	2737	2738	2739	2740	2741	2742	2743	2744	2745	2746	2747	2748	2749	2750	2751	2752	2753	2754	2755	2756	2757	2758	2759	2760	2761	2762	2763	2764	2765	2766	2767	2768	2769	2770	2771	2772	2773	2774	2775	2776	2777	2778	2779	2780	2781	2782	2783	2784	2785	2786	2787	2788	2789	2790	2791	2792	2793	2794	2795	2796	2797	2798	2799	2800	2801	2802	2803	2804	2805	2806	2807	2808	2809	2810	2811	2812	2813	2814	2815	2816	2817	2818	2819	2820	2821	2822	2823	2824	2825	2826	2827	2828	2829	2830	2831	2832	2833	2834	2835	2836	2837	2838	2839	2840	2841	2842	2843	2844	2845	2846	2847	2848	2849	2850	2851	2852	2853	2854	2855	2856	2857	2858	2859	2860	2861	2862	2863	2864	2865	2866	2867	2868	2869	2870	2871	2872	2873	2874	2875	2876	2877	2878	2879	2880	2881	2882	2883	2884	2885	2886	2887	2888	2889	2890	2891	2892	2893	2894	2895	2896	2897	2898	2899	2900	2901	2902	2903	2904	2905	2906	2907	2908	2909	2910	2911	2912	2913	2914	2915	2916	2917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International Tabular Summary: Financial Resources and their Management

STATISTICS RELATING TO THE SOURCES AND AMOUNT OF REVENUE (concluded)

COUNTRY	Year	Amount of contributions		Public subsidies		Interest		Total revenue including miscellaneous receipts		Contributions as percentage of total revenue	REMARKS
		Total (a)	Average per insured (b)	Total (a)	Average per insured (b)	Total (a)	Average per insured (b)	Total (a)	Average per insured (b)		
POLAND: (a) = 1,000's of zloty ; (b) = zloty.	1924	84,667	53.85	—	—	403	0 25	89,540	55	94.55	
ROUMANIA : Former Kingdom: (a) = 1,000's of lei ; (b) = lei.	1914	1,949	—	—	—	—	—	2,020	—	96 5	
	1919	2,942	—	—	—	—	—	3,074	—	95 7	
	1920	10,408	—	—	—	—	—	11,527	—	90 3	
	1921	19,297	—	—	—	—	—	21,304	—	90 6	
	1922	31,767	—	—	—	—	—	34,188	—	92 9	
	1923	44,255	—	—	—	—	—	46,020	—	96 2	
	1924	79,278	144.14	—	—	—	—	82,237	149 52	96 4	
	1925	93,418	—	—	—	—	—	96,709	—	96 6	
Ardeal: (a) = 1,000's of lei , (b) = lei	1919	10,361	—	—	—	—	—	10,515	—	98 5	
	1920	43,350	—	—	—	—	—	43,685	—	99.2	
	1921	39,117	—	—	—	—	—	44,541	—	87 8	
	1922	78,310	—	—	—	—	—	82,181	—	95 3	
	1923	95,363	—	—	—	—	—	100,928	—	94 5	
	1924	152,288	370.42	—	—	—	—	172,924	420 61	88.1	
	1925	147,956	—	—	—	—	—	152,731	—	96 9	
Bukovina: (a) = 1,000's of lei , (b) = lei.	1922	5,966	—	—	—	—	—	6,289	—	94 9	
	1923	8,635	—	—	—	—	—	9,250	—	93 4	
	1924	13,974	388 16	—	—	—	—	14,601	405 58	95 7	
SERB-CROAT-SLOVENE KINGDOM: (a) = 1,000's of dinars (b) = dinars.	1923	294,772	518.7	—	—	—	—	228,178	526 6	98 5	
	1924	93,867	427	—	—	—	—	197,148	434.25	98 3	

PART IV

INSURANCE INSTITUTIONS

PART IV

INSURANCE INSTITUTIONS

INTRODUCTION

THE FUNCTIONS OF THE INSURANCE INSTITUTION

The object of sickness insurance is to guarantee the insured person at least partial compensation for the loss caused by illness. Every insurance system achieves this end by substituting for individual liability the liability of a social group, which acts as insurer. The insuring group consists of a varying number of actual persons, who are neither directly nor individually liable towards the sick. Their liability is collective and limited to the obligations imposed on them by the law with respect to the collection of funds and the management of the group.

This twofold limitation of the liability of members is obtained by conferring legal personality on the insuring group; and the legal person representing the members of the insuring group is the insurance institution, which focuses all the relations established by the system of insurance. It acts as intermediary between the sick who possess a claim and the members liable to such claim. Towards the beneficiaries it assumes direct liability for the payment of benefits, and in return acquires the right to the members' contributions.

The organisation of a system of insurance therefore presupposes the formation of insuring groups and the creation of insurance institutions. The formation of the groups may be left to the initiative of the members or undertaken by the authorities. The law may impose territorial or occupational grouping, or leave those concerned to choose their own system of organisation. Similarly,

the insured may be bound to affiliate to a specified institution, or they may be given a choice between certain types of institutions.

The management of compulsory insurance may be undertaken by the authorities, or entrusted to independent bodies representing the insured, employers, and sometimes the authorities, or left entirely to the mutual benefit societies of the insured.

If the State does not itself administer insurance, it takes the necessary measures to protect the interests of insured and employers. It reserves the right to grant legal recognition to the institutions, and keeps a constant check on their work.

These various problems and the solutions adopted in the national laws will be discussed in the four following Chapters:

Chapter I: Methods of Grouping the Insured and their
 Affiliation to Institutions.

Chapter II: Formation and Machinery of Institutions.

Chapter III: Supervision.

CHAPTER I

**METHODS OF GROUPING THE INSURED AND THEIR
AFFILIATION TO INSTITUTIONS**

§ 1. — **Methods of Grouping the Insured**

Insured persons have to unite in order to form an insurance institution or, more exactly, a group of insurers. The law may prescribe the basis of organisation or it may leave insured persons as a whole, or certain classes of them only, a choice between various types of institutions.

The methods of grouping may be reduced to three: grouping by trades, territorial grouping, and religious or political grouping.

The characteristics of these three methods of grouping will be indicated briefly, and the provisions of the various national laws will be summarised and classified according to the methods of grouping which they prescribe.

GROUPING BY TRADES

The trade group is an organisation of insured persons engaged in the same occupation. It may be confined to members of a trade union (trade union fund) or to workers employed by members of the same guild (guild fund). With trade funds one generally associates works funds which organise those persons who, although they are not engaged in the same occupation, are nevertheless employed in one or more undertakings in the same industry and the majority of whom are employed in the same kind of work.

The range of action of a trade insurance institution may cover the entire territory of the country. Such is the case of a national seamen's fund or a trade union fund, the members of which are scattered throughout the country. Generally, however, the scope of a trade fund is more limited and includes only the persons in the

same occupation whose place of work is situated within some smaller territorial division, such as a department, an urban centre or a commune. In the case of a works fund the territorial basis becomes even narrower: an institution of this kind is constituted solely by workers employed in the undertaking, so that the contact between the insured persons is particularly close. Thus, the method of grouping by trades is always subject to a territorial limitation, although the essential criterion for the recruitment of the insured remains the occupation in which they are engaged.

This method of grouping has certain advantages, in that the risks represented by the insured are similar, and in that it promotes solidarity among the members of a fund and affords an opportunity of co-operation between employers and workers.

In the first place the similarity of the occupation of members of a trade union fund or of a guild fund implies that they are all exposed to the same risks. The members of a works fund, although they do not necessarily all follow the same trade, are yet working under similar conditions, so that the sickness rate is likely to be about the same for all. The regular fulfilment of actuarial forecasts may therefore be relied on, and the rate of contributions can be easily adjusted to the risks.

The community of interests which links the members of the same occupation or the persons employed in the same undertaking inevitably develops a spirit of solidarity among the workers. This spirit may serve to secure an effective mutual supervision by the members and so to eliminate fraud and malingering, especially when the territorial basis of the fund is small and the insured live in close touch with one another.

Finally, the method of grouping by trades may to a certain extent contribute to promote a useful collaboration between employers having similar undertakings as well as between employers and workers of one or more undertakings in the same industry.

Whatever may be its advantages, one cannot ignore the criticisms which have been passed on the method of grouping in trades. The most serious criticism points to the fact that the stability of such institutions is liable to be upset by economic disturbances. A serious crisis may have disastrous effects upon them. Total or partial unemployment, the stoppage of work in one or more undertakings may reduce the number of members and render it difficult or even impossible to collect contributions, so that the institution may undergo severe financial injury and indeed be forced to close.

Two other criticisms of the method of grouping by trades are directed especially against works funds. It is pointed out on behalf of territorial institutions that works funds might in certain cases operate at the expense of other insurance institutions. In small manufacturing centres the presence of a works fund to which the insured in the area belong may make it difficult to set up sufficiently strong institutions for those workers who are outside the undertaking. From the standpoint of the labour movement works funds have been attacked on the ground that they gradually lose their character as self-governing institutions and that the influence of the employers' representatives often becomes preponderant.

TERRITORIAL GROUPING

Territorial grouping means that insured persons working in a particular area belong to the same fund, whatever may be their occupation.

The law may insist upon the rigid application of this rule, and in that case all the insured persons in the district are obliged to belong to a single territorial fund.

Generally, however, the territorial fund does not obtain all the insured persons present in its district and a varying fraction is affiliated to trade funds (miners and seamen particularly) or even to religious or political funds.

The law may also allow the formation within an area of two territorial funds, one of which is reserved for agricultural workers while the other is open to all other classes of wage-earners.

General territorial funds organising the whole of the insured persons whose place of work is situated within their area (except persons belonging to rural, occupational and other funds) possess numerous advantages, especially as regards the mutual compensation of good and bad risks, freedom from disturbance by economic fluctuations, the organisation of the medical service, and the unification of insurance against various risks.

A general territorial fund will contain members from every trade; it does not select its risks, and the sickness rates of its members vary widely. The various risks, however, are likely, to compensate one another, since they represent differences in the number and severity of illnesses. Moreover, a local general fund is much less exposed to the effects of an economic crisis than a trade fund. Unemployment and the closing of undertakings cannot

appreciably affect its membership; for, if the territorial basis is sufficiently large, the crisis, however serious it may be, can hardly result in the depopulation of a whole district.

The stability of its membership and the concentration of all the insured in a definite area enable a territorial fund to organise efficiently the administration of benefits in kind.

As all the insured are grouped round the insurance institution, it is possible to place at their disposal suitable medical aid and take preventive measures on their behalf. In countries where the management of insurance is solely in the hands of trade, religious, political or other funds, the law deprives insurance institutions of the right of granting benefits in kind and has organised a medical service on a territorial basis; thus, British legislation, which makes approved societies the legal insurers, allows them to administer cash benefits only, having entrusted the organisation of the medical service to the territorial insurance committees. The division of the national territory into a certain number of areas also facilitates supervision by the public authorities, as well as mutual supervision by members in the case of funds which are partly territorial and partly trade in basis.

Finally, when its membership is not reduced by the presence of trade funds and special territorial funds for agricultural workers, a local general fund may facilitate to a large extent the unification for administrative purposes of the various branches of insurance. A sickness fund of this type is especially suited to undertake the administration of insurance against the other physical risks as well as against the economic risk of unemployment. Wherever a unified system of social insurance has been attempted or has been actually put into practice, the territorial principle of organisation has been used as the basis of the system. The example of the Bulgarian, Czechoslovak, Yugoslav, and Russian laws is proof of this assertion.

OTHER METHODS OF GROUPING

The law may allow the formation of funds by insured persons having the same religious, political or moral convictions or even persons adopting a certain rule of conduct, such as those who promise not to drink alcoholic liquors.

Funds of these different types may operate either throughout the national territory or only accept as members persons residing or working within a certain area.

This method of grouping, even when the fund has a territorial basis, often entails the creation of a very large number of administrative units concerned with compulsory insurance, many of which may not be financially sound. Hence result much overlapping, an increase in the cost of administration, difficult and expensive supervision, and almost insuperable obstacles to efficient organisation of medical aid.

Only in Great Britain and the Irish Free State has the administration of compulsory insurance been entrusted to societies based on these different methods of grouping as well as to trade funds. On the Continent such institutions are only tolerated in exceptional cases.

CLASSIFICATION OF LAWS ACCORDING TO METHODS OF GROUPING

Each State has solved the problem of creating insurance institutions with reference to its particular social and political conditions.

Whenever a compulsory sickness insurance Act has been drafted, the legislature has usually had to make allowance for existing insurance organisations covering a certain proportion of the persons included in the scope of the new law. There are thus insurers available whose technical experience and accumulated resources render them well adapted to manage compulsory sickness, and the law has therefore generally treated the existing organisations with consideration, maintaining them, at least to some extent, in the statutory system. The object of this policy was to avoid creating useless opposition to compulsory insurance, and no suspicion that it was desired to destroy established institutions could thus arise.

The chief organisations which might be taken into account as a basis for compulsory sickness insurance legislation were mutual benefit societies, trade funds, whether of employers or workers, and works funds. If such institutions were already in existence when insurance was made compulsory, the law might merely confer on them the quality of statutory insurers, creating new institutions only for the purpose of grouping workers who had not already insured voluntarily.

The history of British law is the most striking example in this respect. When the National Health Insurance Act came into force (15 July 1912), a substantial number of the persons covered by the Act had already insured by joining a friendly society, a trade union

fund, a works fund, etc. This made it possible to introduce compulsion without proceeding to create a vast network of new institutions, for the management of insurance could be entrusted to the voluntarily created institutions.

In Central Europe, too, the legislatures have been guided by the desire to make use of the existing mutual benefit movement. In Germany when the first sickness insurance Act was being drafted, there were a large number of voluntary insurance institutions — industrial works funds, building funds, guild funds, mining funds, municipal funds — on all of which the compulsory sickness insurance Act conferred the quality of statutory insurers on certain conditions. According to the draft Social Insurance Code: “when statutory sickness insurance was originally introduced, the legislature was guided by the principle of a system of insurance on a corporative basis and as decentralised as possible, while maintaining existing institutions ”¹.

In Austria and Hungary existing institutions — works funds, building funds, mining funds, mutual benefit societies — were similarly accepted as statutory insurers when sickness insurance was made compulsory.

The desire to make allowance for the existing voluntary organisations also seems to be guiding the French legislature, which in its Bills for compulsory sickness insurance, now being discussed by the Parliamentary Committees, reserves a large field of activity for the many mutual benefit societies.

On the contrary, in countries where the mutual benefit movement was of little importance when compulsory insurance legislation was passed, or had been much weakened by the war or revolutions and their financial and economic effects, it has had to be supplemented by the creation of entirely new organisations.

Sometimes, even where institutions were already in existence, the desire to transform them with a view to national unification has led to their replacement by new unified groups. This applies particularly to the new States created by the Peace Treaties of 1919-1920. In Poland, for instance, in the various territories which for more than a century had belonged to Russia, Germany, and Austria-Hungary, there were several types of insurance institution. The publication *Social Insurance*, issued by the Ministry of Labour and Social Assistance, describes the difficulties to be overcome in the following terms:

¹ *Entwurf einer Reichsversicherungsordnung*, p. 53. Berlin, 1909.

Quite apart from the difficulties due to the many and various regulations and the almost complete lack of officials experienced in this field of administration, the heaviest task was that of creating the new bodies capable of replacing the existing institutions, which had their headquarters and often all their organs outside the territory transferred to Poland ¹

The same report states that "in all its transitional measures the Ministry of Labour and Social Assistance was inspired by the same guiding principle that later found expression in all legislation and administration connected with social insurance — the idea of organising a single system, comprising all types of insurance for reasons of economy, and resting on the principle of territorial institutions to the exclusion of all employers, occupational or other institutions" ².

The situation was similar in the countries neighbouring Poland which before the Revolution belonged to the Russian Empire: Latvia and Esthonia. There, too, entirely new insurance institutions had to be created.

Russia, too, may be classed in this group. The sickness funds established in 1912 were radically transformed after the Revolutions of March and October 1917. The Communist experiment from 1918-1920 in social assistance by the State, to which all able-bodied citizens owed their labour, did not yield the expected results. The introduction of the new economic policy involving the creation of private undertakings, the suppression of compulsory labour service, and the reduction of State supplies, brought to light the need for an insurance system based on territorial institutions. The principles for its working were laid down in the Decree of 15 January 1921 and the Labour Code of 1922.

The above remarks will explain why in certain States there are extremely different types of insurance institution, whereas in others there is only one type of insurer or a small number of uniform types.

If the legal origin of the institution is left out of account, the countries which have adopted the principle of compulsory sickness insurance may be classified in the four following groups:

(1) *Countries with only a territorial grouping of the insurance institutions.* Very few countries may be placed in this group; only the Bulgarian and Lithuanian laws adopt a territorial basis alone.

¹ MINISTRY OF LABOUR AND SOCIAL ASSISTANCE: *Les assurances sociales en Pologne*. Report submitted by the Polish Delegation to the Seventh International Labour Conference; p. 9. Warsaw, 1925.

² *Ibid.*, p. 12.

(2) *Countries with only an occupational grouping of the insurance institutions.* Only two countries, Esthonia and Latvia, make occupational institutions the sole statutory insurers.

(3) *Countries with territorial, occupational, and religious or political groups side by side.* The large majority of countries in which sickness insurance is compulsory may be placed in this third group. In some of these countries, when the compulsory insurance Acts were being drafted, it was decided to give predominant influence to the territorial groups, but also to use the existing occupational or mutual benefit institutions or to authorise the creation of new insurers of these two types (Austria, Czechoslovakia, France (Alsace-Lorraine), Germany, Hungary, Italy (new provinces), Norway). In some countries there are besides the territorial funds either only mutual benefit funds (Portugal, Switzerland) or only occupational funds (Greece, Japan, Luxemburg). Finally, in some of them, although the system is based on the territorial principle, exceptions to the principle have been allowed for certain specified groups of workers (miners, railwaymen), account being taken not of existing institutions but of the special conditions of their work (Poland, Russia, Serb-Croat-Slovene Kingdom).

(4) *Countries with only religious or political and occupational groups.* The laws of these countries do not provide for institutions based on the territorial principle. Compulsory insurance is administered solely by mutual benefit societies and trade funds. This system has been adopted in Great Britain and the Irish Free State, where the British Act is in force subject to various modifications.

§ 2. — Systems of Affiliation to Institutions

The liability to insure may either involve the inclusion of the insured person in a specified insurance institution or leave him free to choose the fund he prefers. In the first case, that of "compulsory affiliation" (*obligation de caisse*, *Kassenzwang*), he cannot choose his insurer, whereas in the second, that of "compulsory insurance" (*obligation d'assurance*, *Versicherungszwang*), the choice of a particular fund is left to the person concerned.

Where an Insurance Act adopts the principle of compulsory affiliation, it is possible to encourage the creation of sufficiently

large funds in small numbers, for if the choice of an insurance institution is not left to the insured, the law, by creating large territorial or occupational funds, may make the estimates of the probable occurrence of sickness more accurate. Owing to the fact that the gravity of the risk of sickness varies with the district in which the insured live, the area of the funds may be made large enough to allow the inequalities to cancel out, thereby preventing too great a multiplication of institutions and simplifying the work of supervising the funds. Compulsory affiliation permits of the elimination of small funds which are never sure of their membership and whose success is generally due only to particularly good administration and a favourable morbidity rate.

In point of fact, however, the choice of system has not been based solely on theoretical considerations. Where it was necessary to respect existing mutual benefit or occupational institutions, on which the quality of statutory insurers was conferred, either alone or in competition with new organisations, the principle of compulsory affiliation had to be given up altogether or in part. Where on the contrary entirely new institutions, territorial or occupational, were made responsible for the administration of sickness insurance, the principle has been applied in full.

Owing to the difference in the conditions prevailing when the various Sickness Insurance Acts were drafted, there are three different systems of affiliation: those of free affiliation, compulsory affiliation, and subsidiary compulsory affiliation which combines features of the other two.

FREE AFFILIATION

The first system, that of free affiliation, leaves each person entirely free to choose his institution. The State merely demands that persons fulfilling certain conditions shall be insured, without bringing any pressure to bear to make them members of any particular insurance organisation. The freedom of choice is so large that it is even allowable not to join a statutory insurance institution at all. For persons who do not choose an insurer, the State is satisfied to organise a system of compulsory thrift, subject to the supervision of the authorities, which enables the insured to claim statutory benefits when they fall ill. The system of free affiliation has been adopted only in Great Britain and the Irish Free State.

COMPULSORY AFFILIATION

In the system of compulsory affiliation, every person liable to insurance automatically becomes a member of an insurance institution on the day he enters the employment rendering him liable to insure. The obligation to belong to a particular fund is absolute. In the group of laws in which this system has been adopted, a distinction should, however, be made between the three following categories.

(1) Laws under which the territorial (sometimes occupational) insurance institutions are intended to act as insurers for all physical risks (Bulgaria, Poland, Russia¹, Serb-Croat-Slovene Kingdom).

An insured person automatically joins the territorial fund in whose area his workplace is situated. Only transport workers, owing to the peculiar nature of their occupation, are affiliated to special funds of an occupational nature (Poland, Russia, Serb-Croat-Slovene Kingdom).

(2) Laws limiting the insurance liability to certain classes of workers, either industrial workers generally (Esthonia, Greece, Japan, Latvia, Roumania) or certain specified occupations (miners and seamen in France). In this group of laws the monopoly of insurance belongs to occupational funds. Any person whose occupation is covered by the insurance system belongs to the special fund for the undertaking in which he is employed or a joint fund for several undertakings².

(3) Laws which establish side by side with a general insurance system based on subsidiary compulsory affiliation a special system of compulsory affiliation for certain classes of workers (miners in Czechoslovakia and Germany). These laws have created special institutions for certain groups of occupations (miners). Miners are compulsorily insured and placed outside the general insurance system, although a number of regulations of that system also apply to them, and it is not open to them to join the mutual benefit, territorial or occupational funds in the general system. The principle of compulsory affiliation applies to them, and they must belong to the special funds created for them.

¹ The Russian insurance institutions also cover the economic risk of unemployment.

² In Japan workers cannot choose their insurer. If the undertaking in which they are employed has a fund, they belong to that fund; otherwise they are insured in the regional insurance office.

SUBSIDIARY COMPULSORY AFFILIATION

The distinguishing feature of the system of subsidiary compulsory affiliation is that, while each compulsorily insured person is left free to choose his insurer, if he does not make use of his right within a specified period, he automatically becomes a member of a specified institution. As a rule he may join a mutual benefit or occupational institution, failing which he automatically becomes a member of a territorial organisation. Affiliation to a mutual benefit or occupational society is considered by the laws in this group as a fulfilment of the obligation to insure, and it means that the person in question is not required to join any other insurance institution.

This system has been adopted in Austria, Czechoslovakia, France (Alsace-Lorraine), Germany, Hungary, Italy (new provinces), Norway, Switzerland. The methods of applying the principle, however, differ markedly from one country to another. Thus the conditions concerning the right of a mutual benefit fund to accept or refuse a candidate for admission are not the same everywhere, although it is generally admitted that a society may refuse a person who obviously constitutes a bad risk. But once admitted, he may not be expelled for reasons of age or health.

If a compulsorily insured person does not join a mutual benefit fund or has been refused by it, he loses the right to choose his insurer. He then becomes a member, either of an occupational fund if the undertaking in which he is employed has such a fund, or of a territorial fund (Austria, Czechoslovakia, Germany, Switzerland).

In all the laws establishing a system of subsidiary compulsory affiliation, certain groups of persons are however not free to choose their insurer, and the principle of compulsory affiliation applies to them. This is for instance the case for workers whose employers belong to a guild with a special fund (Austria, Czechoslovakia, Germany), workers in the transport industry, the postal and telegraph service, and tobacco factories (Hungary), and workers belonging to a trade union with a trade union fund (Norway).

§ 3. — Institutions and Systems of Affiliation in National Legislation

Under this head the various provisions concerning the methods of grouping the insured and the systems of affiliation contained in the different national laws are studied, the countries being taken in

alphabetical order. The account of each national law is accompanied by statistics showing, among other things, the number of institutions and the membership of the different types of funds.

AUSTRIA

The Act of 20 November 1922 (section 14) provides for the institution of territorial funds, occupational funds and mutual benefit funds. There are five principal types of institution:

(1) The territorial funds set up in each judicial district at the seat of the district court are intended in particular for industrial workers (Federal Act of 21 October 1921, section 6). Provision is also made for the establishment at the seat of each political authority of an agricultural fund for agricultural workers, covering the whole of a province or a district of a province which forms the geographical unit

(2) Works funds may be set up by an employer or the employers of several neighbouring undertakings if they employ a minimum number of persons liable to insurance.

(3) Guild funds (*Genossenschaftskrankenkassen*) are created by the undertakings of members of the guilds established by the Industrial Code of 1859.

(4) Mining funds (*Bruderladen, Knappschaftskassen*) are formed for workers employed in mines in accordance with the provisions of mining legislation, and they grant their members the same benefits as those payable to industrial and commercial workers.

(5) Mutual benefit or association funds (*Vereinskrankenkassen*) are established in accordance with the law on mutual benefit societies, and on certain conditions were allowed to act as statutory insurers when the Act came into force.

The system of subsidiary compulsory affiliation is adopted. Any person liable to insurance, unless employed in an undertaking in which there is a guild fund, may insure in an association fund, provided that it was established under the Act of 26 November 1852 on mutual benefit societies and reorganised in accordance with the Sickness Insurance Act (section 60). If he does not choose such a fund, he becomes a member of a territorial fund (district fund) or an occupational fund (works fund, mining fund) as the case may be.

Affiliation to a district fund is compulsory for all persons liable to insurance employed in the area of the fund if they are not insured against sickness in some other fund established in accordance with the provisions of the Act. Membership dates from the day on which the person enters an employment making him liable to insurance and terminates if the member can show that he is insured against sickness with another statutory insurer (section 13).

The same provisions apply to affiliation to works funds. If an insured person does not voluntarily join an association fund, he becomes a member of the works fund if such a fund has been established for the workers employed in the undertaking where he works. Such persons cannot leave the works fund while they continue in their employment, unless they can prove that they are insured against sickness in a mutual benefit fund (section 46).

Affiliation to a guild fund exempts a person liable to insurance from joining any other sickness fund constituted in accordance with the provisions of the Act (section 58). Membership of such a fund is compulsory and may never be replaced by affiliation to an association fund.

In 1917 Austria adopted a policy tending to reduce the number of funds, to close down the small funds with inadequate resources and to concentrate the insured in large funds, with the object of making the sickness insurance system a suitable basis for organising invalidity insurance. The Act of 6 February 1919 provided for the dissolution of a certain number of institutions, or made possible their dissolution by administrative action. Thus all funds with a membership of less than 500 in communes with a population of under

10,000, or less than 1,000 in larger communes, were dissolved, or at least deprived of the right to administer compulsory insurance. In exceptional cases such funds could be allowed to continue their operations if they proved that they were able to offer the insured considerable advantages as compared with other funds. The administrative dissolution of the funds which could not offer adequate guarantees of stability and efficiency was entrusted to the special provincial committees established by the Act. The effects of the 1919 Act appear from the following table

NUMBER OF SICKNESS FUNDS

Year	Territorial funds	Works funds	Guild funds	Mutual benefit funds	Mining funds
1919	88	114	187	49	28
1921	69	34	45	31	26
1924	67	31	45	29	27
1925	65	31	49	27	—

The next three tables show the changes in membership of the different types of funds and in the average membership per fund, and the percentage distribution of the insured by type of fund.

AGGREGATE MEMBERSHIP OF EACH TYPE OF FUND

Year	District funds	Works funds	Guild funds	Mutual benefit funds
1919	270,285	47,370	144,018	292,373
1920	348,768	42,524	197,713	380,510
1921	441,790	32,006	207,397	419,855
1922	559,715	43,275	204,280	399,726
1923	526,435	36,674	217,429	365,469
1924	562,712	36,261	257,837	391,724
1925	554,845	34,682	262,750	374,618

AVERAGE MEMBERSHIP OF EACH TYPE OF FUND

Year	District funds	Works funds	Guild funds	Mutual benefit funds
1919	3,074	416	770	5,966
1920	4,912	664	2,708	10,569
1921	6,402	941	4,609	13,543
1922	8,746	1,396	5,107	12,894
1923	8,491	1,222	4,726	12,182
1924	8,399	1,169	5,724	13,507
1925	8,536	1,119	5,362	13,875

PERCENTAGE DISTRIBUTION OF MEMBERS BY TYPE OF FUND

Year	District funds	Works funds	Guild funds	Mutual benefit funds
1919	35 8	6 3	19 1	38 7
1920	35 9	4.4	20 4	39.2
1921	40 1	2 9	18 8	39.1
1922	46.3	3 6	16 9	33 1
1923	45 9	3 2	18 9	31 9
1924	45 0	2 9	20 7	31 3
1925	45 2	2 8	21 4	30 5

These tables show the growing importance of the territorial groups, the absolute and relative reduction in the membership of the works funds, the slight increase in the membership of the guild funds, and the concentration which has taken place in the mutual benefit funds.

BELGIUM

SEAMEN'S INSURANCE

There is no compulsion to insure in respect of the benefits payable by ship-owners in the event of sickness or injuries under sections 102 et seq. of the Commercial Code. They are free to organise their method of covering possible liabilities in any way they like.

With respect to other benefits than those for which the shipowners are responsible, on the contrary, persons liable to insurance are required to join the Relief and Provident Fund for Seamen Sailing under the Belgian Flag. This fund in its present form was set up by the Royal Decree of 28 November 1885, amended by the Decrees of 5 June and 29 October 1888, 30 September 1900, and 31 October 1908, 25 June 1922, 20 February 1923, 17 March 1925, and 24 March 1926, and has a monopoly of sickness insurance.

BULGARIA

Under the Act of 6 March 1924, every wage-earning and salaried employee of a State, public, or private establishment, undertaking, or estate is bound to insure in the Social Insurance Fund. The State is alone responsible for the management of the fund, its administration being entrusted to certain central bodies (Ministry of Commerce, Industry, and Labour) and local administrative authorities (labour inspectors) grouped in accordance with the territorial principle.

The Bulgarian law has adopted the principle of compulsory affiliation, and the insured have no right to choose any other institution than the Social Insurance Fund (section 5).

CHILE

The new Chilean Act permits the territorial, occupational, and mutual benefit forms of grouping side by side. According to the final text of the Act on sickness and invalidity insurance (No. 4,054 of 8 September 1924 as established by Decree No. 34 of 22 January 1926), the administration of insurance is entrusted to a body comprising a Central Fund and local funds in the chief towns of the departments (section 6). Under certain conditions, however, occupational funds (works funds and the funds of employers' associations) and mutual benefit funds may also undertake compulsory sickness insurance (section 2).

CZECHOSLOVAKIA

The Act of 9 October 1924 provides for the institution of territorial funds, and also authorises occupational and mutual benefit funds to administer compulsory insurance. There are four types of funds:

(1) Territorial or district funds established in principle at the seats of all political authorities of first instance.

(2) Works funds and guild funds which, when the Act came into force, had a membership of not less than 4,000.

(3) Mutual benefit funds of various kinds: association sickness funds established in accordance with the Act of 26 November 1852, mutual benefit funds established in accordance with the Act of 16 January 1892, and salaried employees' mutual benefit funds. Like the occupational funds, mutual benefit societies may not act as statutory insurers unless when the Act came into force they had a minimum membership of 4,000 (2,000 in the case of salaried employees' mutual benefit funds).

(4) District mining funds, for the area of each mining authority, which are established in accordance with the Act of 11 July 1922 on miners' insurance. They are independent bodies so far as sickness insurance is concerned, and act as local branches of the Central Benefit Society for miners' invalidity insurance.

The Czechoslovak law allows the insured a certain freedom of choice of insurer. Any person liable to insurance may join a mutual benefit organisation unless an occupational fund has been established for the workers in the undertaking where he is employed. If he makes no use of his right, he becomes a member of the competent territorial fund for his place of work.

Affiliation to an association sickness insurance institution or a registered mutual benefit fund exempts the persons in question from insurance with a territorial or occupational fund (sections 28 and 29). Salaried employees have a further right to choose a registered mutual benefit fund which, before 1 January 1924, insured only the persons subject to the Act on private employees' pension insurance and on that date had a membership of not less than 2,000. This right is not granted to persons for whom pension insurance became compulsory by the Act of 5 February 1920 (section 29, subsection 2).

For all these persons affiliation to any of the three types of funds is not automatic but requires their consent (section 30).

If a person liable to insurance has not affiliated to one of these funds and is employed in an undertaking for which there was a works fund in operation on 1 January 1924, he must insure with that fund (section 26, subsection 1). Similarly, if he is employed by a person who is bound to belong to a guild which has established a guild sickness insurance institution, he automatically becomes a member of the institution (section 27).

If he is employed in an undertaking for which no occupational fund has been formed and has not joined an association sickness insurance institution or a registered mutual benefit fund, he automatically becomes a member of the territorial sickness insurance institution. The way of distributing the insured among the different territorial institutions is for agricultural and forestry workers to become members of the agricultural sickness insurance institution in whose area they perform work or render services making them liable to insurance (section 25, subsection 1), while other wage-earners whose work is based on a contract of work, service or apprenticeship and is not accessory or casual become members of the district sickness insurance institution for the area in which they are employed (section 24, subsection 1).

ESTHONIA

According to the Act of 23 June 1912, as amended, there are two types of sickness funds: special works funds formed in undertakings employing a specified minimum number of persons and general funds common to several similar undertakings. The latter are not territorial funds, as several may be found side by side in one and the same administrative area. At Tallinn (Reval), for instance, there are two general funds, one for municipal, the other for private undertakings.

Affiliation to an occupational fund is compulsory from the date on which work is taken up in the undertaking, and terminates not later than one month after the cancellation of the contract of work (section 279 of the Industrial Code).

The following tables are taken from the information supplied by the Estonian Central Statistical Office.

NUMBER OF SICKNESS FUNDS

Year	Number of general funds	Number of special works funds	Total
1919	5	13	18
1920	6	13	19
1921	8	14	22
1922	9	16	25
1923	15	16	31
1924	15	16	31

The two following tables show the growing importance of the general funds. The first gives the number of persons insured in the two types of funds, the second the average membership per fund.

MEMBERSHIP OF SICKNESS FUNDS

Year	General funds		Special funds	
	Number of members	Per cent. of total insured	Number of members	Per cent. of total insured
1919	4,577	38.0	7,470	62.0
1920	7,759	53.9	6,642	46.1
1921	12,008	63.0	7,042	37.0
1922	15,543	60.9	9,940	39.1
1923	21,582	63.5	12,409	36.5
1924	22,558	67.2	11,003	32.8

AVERAGE MEMBERSHIP PER FUND

Year	All sickness funds	General funds	Special funds
1919	669	915	575
1920	758	1,293	511
1921	866	1,501	503
1922	1,019	1,727	621
1923	1,096	1,439	775
1924	1,083	1,504	688

FRANCE

At present France has no compulsory sickness insurance system covering the whole working population. Insurance is compulsory only for workers employed in Alsace-Lorraine, who are subject to the system set up by the German Insurance Code (amended). In addition, there are two special systems of insurance, for miners and seamen.

In Alsace-Lorraine (Departments of the Haut-Rhin, Bas-Rhin, and Moselle) there are the types of funds prescribed in the German Insurance Code, namely, territorial, occupational, and mutual benefit funds.

The local funds are grouped on the territorial system, and there has been no change in their number since 1919. The rural funds for which the Insurance Code provides are not to be found in Alsace-Lorraine.

Occupational institutions are represented by works funds, guild funds, and mining funds. The number of the first has fallen owing to the closing down of funds or their amalgamation, but there has been no change in the number of guild funds. The mining funds are attached to the funds organised for Alsace-Lorraine by the Mines Act of 16 December 1873. By section 147 of that Act they must provide their members with medical and cash benefit in the event of illness, but they have transferred their obligations to the works funds set up in all mines in the three Departments.

The approved mutual benefit funds, which may in certain cases take the place of the statutory sickness funds, had their headquarters in Germany before the Armistice. As from 1 January 1919 they were dispossessed in favour of the Alsace-Lorraine sickness funds. Under the French system two approved mutual benefit funds were formed in 1921.

NUMBER OF SICKNESS FUNDS

Year	Local funds	Works funds	Guild funds	Railway funds ¹	Post office funds	Approved mutual benefit funds	Total
1919	27	227	10	—	4	—	264
1920	27	217	10	1	2	—	257
1921	27	210	10	1	2	2	252
1922	27	205	10	1	2	2	247
1923	27	205	10	1	2	2	247
1924	27	205	10	—	2	2	246

¹ As from 1 January 1924, the sickness fund of the Alsace-Lorraine railways ceased, in virtue of the Act of 30 December 1923, to be governed by the provisions of Book II of the Social Insurance Code.

The two following tables give the average membership per fund and the percentage distribution of members by type of fund from 1919-1924, the railway and post office funds being counted separately.

AVERAGE MEMBERSHIP PER FUND

Year	Local funds	Works funds	Guild funds	Railway funds	Post office funds	Approved mutual benefit funds
1919	6,841	672	334	—	—	—
1920	7,396	672	397	32,971	1,458	—
1921	7,594	710	436	29,713	1,227	479
1922	8,053	777	457	28,032	1,057	1,014
1923	8,787	804	470	27,743	1,029	1,221
1924	9,585	841	491	—	1,075	1,296

PERCENTAGE DISTRIBUTION OF INSURED BY TYPE OF FUND

Year	Local funds	Works funds	Guild funds	Railway funds	Post office funds	Approved mutual benefit funds
1919	54.1	44.9	1.0	—	—	—
1920	51.8	37.8	1.1	8.5	0.8	—
1921	52.5	38.0	1.1	7.6	0.6	0.2
1922	52.6	38.5	1.1	6.8	0.5	0.5
1923	54.0	37.5	1.1	6.3	0.5	0.6
1924	58.6	39.2	1.1	—	0.4	0.5

Although the territorial institutions in Alsace-Lorraine, as in Germany, cover more than half the insured, the system of occupational grouping is used more widely, as will appear from the fact that in 1924 40.7 per cent of the persons liable to insurance in Alsace-Lorraine were members of occupational funds, compared with the figure of 27.2 per cent. for Germany.

France also has two special systems of compulsory sickness insurance in occupational institutions.

The first, created in 1905 for seamen, provides for only one insurance institution, the French Seamen's Provident Fund attached to the Seamen's Disablement Fund.

The second, introduced in 1894, was established for miners. It provides for the creation of miners' benefit funds, each of which covers a geographical area defined so as to include the persons employed in a single concession or the workers in particular branches of the industry. Moreover, a single undertaking may be divided into several mutual benefit societies, or a single society may be set up for neighbouring concessions or undertakings belonging either to one owner or to several concession holders (section 9 of the Act of 1894).

The following table gives information on the number of these societies and their distribution according to the nature of the undertaking:

NUMBER OF MINERS' MUTUAL BENEFIT SOCIETIES

Year	Fuel mines	Iron mines	Other mines	Salt mines	Bituminous shale and sulphur mines	Slate quarries	Total
1913	111	60	11	4	5	—	224
1919	133	58	15	1	3	—	210
1920	147	59	10	1	5	—	225
1921	139	63	13	4	7	5	231
1922	144	61	9	4	6	13	234
1923	133	63	10	4	4	13	227

GERMANY

The Federal Insurance Code provides for four types of insurance institution, two of which are based on the territorial, and two on the occupational principle (section 225), to which should be added the substitute funds, which in some respects are treated as statutory funds and are based on the mutual benefit principle (sections 503 et seq.). Miners' insurance is administered, in accordance with the Act of 1 July 1926, by the Federal Miners' Benefit Society and its

local branches, the district funds and the special funds opened for certain mining undertakings. The following sickness insurance institutions are therefore to be found in Germany.

(1) Local funds (*Ortskrankenkassen*) intended particularly for industrial workers. Besides these there are still special local funds (*besondere Ortskrankenkassen*), based on both the territorial and the occupational principles and created for one or more branches of industry, for one or more types of undertaking, or for only one sex; these funds were in existence before the 1911 Insurance Code came into force; no new fund of this type may be formed.

(2) Rural funds (*Landkrankenkassen*) also based on the territorial principle and intended particularly for agricultural workers and domestic servants as well as persons in itinerant trades.

The general local funds and the rural funds are usually established for the district of a local insurance office. Both types of fund may be found in one and the same district. In exceptional cases there may be either a general local fund or a rural fund only, if the number of persons liable to insurance in the district is not large.

(3) Works funds (*Betriebskrankenkassen*) set up with the consent of the works council for an undertaking employing persons liable to insurance, for the benefit of the persons employed in the undertaking.

(4) Guild funds (*Innungskrankenkassen*) set up for the undertakings of members of the same guild.

(5) Substitute funds (*Ersatzkassen*), which are mutual benefit societies allowed under certain conditions to administer compulsory sickness insurance (section 517).

(6) District mining funds (*Bezirksknappschaften*) and special mining funds (*besondere Krankenkassen*) which are combined in a Federal Miners' Benefit Society (*Reichsknappschaft*). These bodies administer sickness insurance for miners in accordance with the provisions of the Insurance Code.

The Federal Insurance Code adopted the principle of subsidiary compulsory affiliation introduced in 1885, which has been maintained throughout all the changes in the sickness insurance system that have taken place since that date. In principle, any person liable to insurance may join a mutual benefit fund, and it is only if he does not make use of his right that he is affiliated to a territorial fund (general local fund or rural fund), unless he is employed in an undertaking for which an occupational fund has been set up.

If a person liable to insurance joins a substitute fund (*Ersatzkasse*), he is exempt from insurance in a territorial fund. In order to establish his right to exemption he must submit a certificate to his employer showing that he belongs to a substitute fund (section 517). The substitute funds are bound to issue such certificates to their members on application without delay (section 518). On submission of the certificate the employer need not register the person in question with the sickness fund (section 519). The substitute fund has a claim to the full share of the contribution which the employer would have been required to pay to the sickness fund with which the worker in question would have been insured if he had not been a member of the substitute fund (section 520). If a member leaves the substitute fund, the latter must notify the employer within a week (section 521).

If a person liable to insurance does not join a substitute fund, he automatically becomes a member of the competent territorial fund unless an occupational fund has been formed for the workers in the undertaking employing him. If he works in an undertaking for which the employer has created a special fund, either voluntarily with the consent of the works council or on the Order of the Central Insurance Office, he becomes a member of such a fund (section 245, subsection 3).

Similar provisions are in force for the guild funds. If a guild has opened a special fund for the undertakings of its members, the persons liable to insurance who are employed in those undertakings automatically belong to the fund (section 250, subsection 2). This provision does not apply, however, to two groups of workers:

(1) Agricultural or itinerant workers and domestic servants, who are affiliated to a rural fund unless they belong to a substitute fund, even if they are employed in an undertaking belonging to a guild (section 250, subsection 2 and section 235),

(2) Persons employed in an undertaking which the employer has voluntarily affiliated to a compulsory guild or for which a works fund has been set up under section 249 of the Act (works funds set up for workers in temporary building undertakings) (section 250, subsection 3).

If an insured person does not belong to an occupational fund and has not made use of his right to join a substitute fund, he is compulsorily affiliated to a territorial fund. Persons employed in agriculture, itinerant trades or domestic service become members of the rural fund if the law of the State in which they work provides for such funds. Persons in other occupations automatically become members of the general local fund (sections 234 and 237). In default of a general local fund in any district the persons liable to membership of the local fund must join the rural sickness fund (section 237, subsection 1). If, on the contrary, there is no rural fund, the persons liable to membership of a rural fund belong to the general local fund (section 237, subsection 2).

The total number of German sickness funds rose from 18,942 when compulsory sickness insurance was introduced in 1885 to 21,342 in 1913. Owing to the reorganisation of the system by the 1911 Insurance Code the number fell to 9,854 in 1914, a fall of about 54 per cent. This tendency continued after the war, even if allowance is made for the fact that Germany lost 559 sickness funds owing to the reduction of territory.

The mining funds, which numbered 79 in 1924, were dissolved on 1 January 1925, and miners' insurance has been transferred to a single insurer, the Federal Miners' Benefit Society and its district branches.

The following tables show the changes in the number of compulsory sickness insurance institutions and their membership from 1914 to 1925

NUMBER OF SICKNESS FUNDS

Year	Funds set up in accordance with the Insurance Code	Mining funds	Substitute funds	Total
1914	9,854	146	—	10,000
1915	9,826	144	—	9,970
1916	9,517	143	—	9,660
1917	9,489	139	66	9,694
1918	9,411	138	65	9,614
1919 ¹	9,017	128	58	9,203
1920 ²	8,681	124	48	8,853
1921 ³	8,445	123	46	8,614
1922	8,251	88	45	8,384
1923	8,143	77	43	8,263
1924	7,777	79	41	7,897
1925	7,670	51	42	7,763

¹ With the Saar Territory and Memel.

² New territory without the Saar

³ Since 1921, new territory without the Saar and Upper Silesia.

MEMBERSHIP OF SICKNESS FUNDS

Year	Funds set up in accordance with the Insurance Code	Mining funds	Substitute funds	Total
1914	15,609,586	916,081	—	16,525,667
1915	13,840,848	742,935	—	14,583,783
1916	13,500,102	777,572	—	14,277,674
1917	14,176,257	875,878	172 609	15,224,744
1918	14,432,040	950,702	190 052	15,572,794
1919 ¹	15,840 850	1,109,094	290,680	17,240,624
1920 ²	17,088,636	1,277,891	413,083	18,779,610
1921 ³	17,442,378	1,120,853	465,505	19 028,736
1922	18,361,930	1,099,099	723,441	20,184,470
1923	18,112,022	1,071,772	815,610	19,999,404
1924	17,287,841	876,510	957,444	19,121,795
1925	18,234,970	817,845	1,122,541	20,175,356

The tables show that except at the outbreak of war there was a constant increase in membership, although the number of institutions steadily declined. This tendency is brought out even more clearly if the statistics for the funds set up under the Insurance Code, which cover the large majority of the insured, are examined separately

NUMBER OF SICKNESS FUNDS SET UP UNDER THE INSURANCE CODE

Year	Local funds	Rural funds	Works funds	Guild funds
1914	2,788	595	5,524	917
1915	2,785	599	5,487	955
1916	2,754	594	5,228	941
1917	2,751	595	5,205	938
1918	2,706	596	5,174	935
1919 ¹	2,609	538	4,960	910
1920 ²	2,545	511	4,740	885
1921 ³	2,524	496	4,559	866
1922	2,484	485	4,451	831
1923	2,454	473	4,401	815
1924	2,251	449	4,315	762
1925	2,176	437	4,279	778

AGGREGATE MEMBERSHIP OF EACH TYPE OF FUND

Year	Local funds	Rural funds	Works funds	Guild funds
1914	9,714,396	2,096,211	3,408,196	390,783
1915	8,332,637	1,912,898	3,305,711	289,602
1916	8,083,263	1,871,620	3,295,638	249,581
1917	8,309,953	1,898,211	3,745,498	222,595
1918	8,405,148	1,918,661	3,894,056	214,175
1919 ¹	9,795,563	2,027,924	3,730,136	287,227
1920 ²	10,807,194	2,181,344	3,792,024	308,074
1921 ³	11,179,684	2,198,203	3,735,117	329,410
1922	11,949,549	2,139,085	3,898,734	374,562
1923	11,826,278	2,080,740	3,582,356	352,648
1924	11,607,741	2,014,603	3,297,134	368,363
1925	12,333,923	2,053,190	3,404,928	442,929

PERCENTAGE DISTRIBUTION OF MEMBERS BY TYPE OF FUND

Year	Local funds	Rural funds	Works funds	Guild funds
1914	62.2	13.4	21.9	2.5
1915	60.2	13.8	23.9	2.1
1916	59.9	13.9	24.4	1.8
1917	58.6	13.4	26.4	1.6
1918	58.8	13.3	27.0	1.5
1919 ¹	61.8	12.8	23.6	1.8
1920 ²	63.2	12.8	22.2	1.8
1921 ³	64.4	12.6	21.4	1.9
1922	65.1	11.7	21.2	2.0
1923	65.3	11.5	21.3	1.9
1924	67.1	11.7	19.1	2.1
1925	67.6	11.3	18.7	2.4

¹ With the Saar Territory and Memel

² New territory without the Saar.

³ Since 1921, new territory without the Saar and Upper Silesia

Works funds since the beginning have accounted for more than half of the total number of funds. This proportion, however, seems to be altering in favour of the local funds. Thus in 1924, the reduction in the number of local funds in comparison with the pre-war number amounted to over 20 per cent., that of rural funds to over 25, that of works funds to nearly 25, and that of guild funds to nearly 20 per cent.

The tables of membership and percentage distribution bring out the tendency of persons to insure with local funds.

One finds that, for the local funds, there has been an increase of about 27 per cent in membership, in comparison with the 1914 figure and for the guild funds an increase of about 13 per cent, while the two other types of funds have undergone a loss of between 0.1 and 2.3 per cent. of their strength.

The fall in the membership of the institutions set up under the Insurance Code which took place in 1924 may be ascribed in part to the unemployment crisis and in part to the growing importance of the substitute funds, which are particularly favoured by salaried employees.

The part played in Austria by mutual benefit societies is decidedly more important than in Germany. Thus, in 1924, the ratio of the membership of the territorial institutions to that of the mutual benefit societies was 100 to 67 in Austria, and only 100 to 8 in Germany. This difference is brought out clearly by an examination of the membership of the funds. In Germany the territorial institutions cover about three-quarters of the insured; in Austria the district funds cover barely half the total.

GREAT BRITAIN AND NORTHERN IRELAND

In these countries compulsory sickness insurance is administered solely by mutual benefit and occupational institutions. For the administration of the new legislation, the authors of the 1911 National Health Insurance Act intended to make use of the institutions already engaged in insuring wage-earners and salaried employees. Thus both mutual benefit societies (friendly societies, mutual insurance societies formed by insurance companies, collecting societies) and occupational institutions (trade unions and employers' provident funds) became statutory insurers (approved societies).

The *friendly societies* are mutual benefit societies which grant their members sickness benefit and funeral benefit, sometimes also invalidity and old-age benefit. The *industrial assurance companies* insure the lives of workers

for small sums. The *collecting societies* are mutual benefit societies which use the commercial methods of insurance companies. The *trade unions* often undertake unemployment insurance and sickness insurance. The *employers' provident funds* guarantee the insured sickness benefit, as also invalidity and old-age benefit. All such societies, once they have been approved, may share in the administration of compulsory sickness insurance, which they carry on by the side of their voluntary business.

Some of the British approved societies are strongly centralised; others are subdivided into separate branches. The first will have only one office managing all the business of the society. This is the case for all industrial assurance societies, the collecting societies, the trade unions and the employers' provident funds, as well as most friendly societies. Only some of the friendly societies, known as "affiliated orders", form approved societies with branches. The latter, whether called "lodges", "courts" or "tents", are independent and form separate financial entities. They cannot individually obtain legal recognition, but are covered by the recognition granted to the society as a whole.

Some approved societies insure both men and women indifferently, some only one sex.

From the legal and administrative point of view no distinction is made between territorial and occupational societies. No doubt when a centralised friendly society or a branch of a decentralised society was first formed its membership might be concentrated in a single village, town or other territorial division, but in the course of years a fairly large proportion of the members will have left their first place of residence while retaining their membership of the society.

The approved societies may also be divided into those entitled to administer insurance throughout the kingdom, and those competent for only one country—England, Scotland, Wales, or Northern Ireland. The first are called "international societies", the second "national societies".

The forms of the British approved societies¹ are thus very various, and the absence of any territorial principle means that there are hundreds of societies in operation in large centres such as London or Manchester.

The choice of the insuring group is left entirely to the insured. Any person liable to insurance may apply to any approved society for membership (section 41, subsection 1), and is even entitled not to join a society at all. The same freedom is also granted to the insurers, who may admit or reject any person applying to them for membership (section 41, subsection 2). The British law, however, subjects this complete freedom to one limitation. According to section 41, subsection 2, no application may be refused solely on the ground of the age of the applicant. The limitation is justified by the provision that each society shall be credited with "reserve values"² to compensate for any loss that may be incurred from the admission of persons of over 17 years of age.

In order to become a member of an approved society all that is necessary is to make an application in proper form to the society or its representative. The applicant is notified of his acceptance or rejection, but if within a period of three months after the date of such application the applicant is not notified of his rejection, he may consider himself admitted a member of the society (section 41, subsection 3). Nevertheless, in order to prevent abuses on the part of persons liable to insurance, the Act prohibits a person from trying to become a member of more than one approved society or, being a "deposit contributor", from trying to become at the same time a member of an approved society (section 42). The formalities required of the insured are thus reduced to a minimum. In practice most societies do not require a medical examination before admission.

Once admitted to a society it is more difficult for the member to leave, but he may freely transfer during the first two years. As a rule a member who resigns does so because he wishes to join another society. This may

¹ This study of the British institutions leaves out of account the Navy, Army and Air Force Insurance Fund.

² See Part III. Chapter II, p. 507.

often be because he considers another society better for his purposes or it offers more generous additional benefits. If the right to leave a society were not limited, the small societies would run the risk of loss of membership and weakening of their financial position. This is why the British Act has introduced certain limitations on the absolute freedom to resign from a society.

The mere fact that the right to additional benefit depends on having been a member of the society for not less than five years discourages many people from changing their insurer. Further, the Act lays down that membership can be terminated only at the prescribed times and subject to one month's notice (section 43, subsection 1*a*). If, within 30 days of receiving notice of resignation, the society notifies the Minister of Health and the member that it objects to his resignation, and proves that it would be prejudiced in its administration by the retirement of the member, the notice of resignation may be declared null and void (section 43, subsection 1*b*). Further, with the consent of the Minister the society may, during any period not exceeding one year from the date when a valuation result is declared, suspend the right of insured persons to terminate their membership (section 43, subsection 1*c*).

The British system is thus characterised on the one hand by the dispersion of its institutions, which presents serious difficulties in the payment of benefits in kind, and on the other by the right of all persons liable to insurance to join an approved society or not. Some means therefore had to be found for paying benefits in case of sickness to persons covered by the Act who, for any reason, do not belong to an approved society. For this purpose a special fund was created for such persons — the Deposit Contributors' Fund — which is administered by the central departments, but applications for benefits are made through insurance committees in each county or county borough¹. The contributions paid by deposit contributors are credited to a special account to which the employers' contribution and State subsidy are also credited. The sums expended on sickness, disablement or maternity benefit are debited to the account of each deposit contributor, whose right to benefit is suspended when the sums standing to his credit in the fund are exhausted (section 54). Deposit contributors are not entitled to additional benefits. The insurance committees are responsible for this class of insured person and check their right to cash benefit, which they received by postal order from the central insurance authorities. Thus for the deposit contributors the system is no longer that of insurance, but one of compulsory thrift subject to public supervision. This discrimination against deposit contributors has proved a powerful incentive to join an approved society. In practice, about 98 per cent. of the insured belong to such societies.

The following tables contain statistics of the approved societies and their membership in Great Britain and Northern Ireland. The first two show the number and membership of the approved societies and branches of societies in operation in Great Britain in 1912 and 1922.

NUMBER OF APPROVED SOCIETIES¹

Year	Number of approved societies	Number of branches	Total sickness insurance institutions
1912	2,481	14,388	16,869
1922	1,161	7,266	8,427

¹ ROYAL COMMISSION ON NATIONAL HEALTH INSURANCE. *Appendix to Minutes of Evidence*, Part I, pp. 59-60. These figures relate to England, Wales, and Scotland.

¹ According to the *Report of the Royal Commission on National Health Insurance* (London, 1926, p. 167), there are at present 123 insurance committees in England, 17 in Wales, and 34 in Scotland.

MEMBERSHIP OF APPROVED SOCIETIES

Year	Membership			Average membership		
	Approved societies	Branches	Total	Per administrative unit	Per approved society	Per branch
1912	9,458,698	2,936,920	12,395,618	730	3,800	200
1922	11,331,800	3,280,900	14,612,700	1,730	9,900	450

These figures show a considerable reduction in the number of societies and branches, due above all to the fact that many were too small to be able to cover the risk and transferred their obligations to larger societies, in several cases such societies continued to provide for voluntary insurance. The relatively small increase in membership and the considerable rise in the average membership of the institutions suggest that there has been considerable concentration in British sickness insurance.

The next two tables show the number of different types of societies and their relative membership.

NUMBER OF SOCIETIES AND DIFFERENT TYPES ON 31 DECEMBER 1918¹

Type of society	Number	Percentage
Centralised friendly societies	1,072	73
Friendly societies with branches	58	4
Industrial assurance and collecting societies	34	2
Trade unions	224	15
Employers' provident funds	100	6
Total	1,488	100

¹ Report of the Government Actuary on the Valuations of the Assets and Liabilities of Approved Societies as at 31 December 1918

MEMBERSHIP OF APPROVED SOCIETIES OF DIFFERENT TYPES

Type of society	Membership		Average membership per society
	Number	Percentage of total	
Centralised friendly societies	3,451,000	23.8	3,200
Friendly societies with branches	3,290,000	22.7	56,900
Industrial assurance and collecting societies	6,241,000	42.8	182,700
Trade unions	1,449,000	9.9	6,400
Employers' provident funds	120,970	0.8	1,200
Total	14,521,970	100.0	—

These two tables show that the industrial assurance and collecting societies, although few in number, comprise the largest proportion of the insured, the next in relative importance being the friendly societies with or without branches. The industrial assurance societies, collecting societies and friendly societies include about 90 per cent. of the persons liable to insurance, the occupational institutions covering only 10 per cent. of the total.

The variations in the size of the friendly societies are illustrated in the tables below, the first relating to centralised societies, the second to societies with branches

DISTRIBUTION OF CENTRALISED FRIENDLY SOCIETIES BY MEMBERSHIP ¹

Number of members	Societies		Membership	
	Number	Percentage of total	Number	Percentage of total
1 - 1,000	684	62.5	236,259	2
1,001 - 10,000	317	28.9	1,130,951	10
10,001 - 50,000	68	6.2	1,593,547	13
50,001 - 100,000	13	1.2	983,738	9
100,001 and over	13	1.2	7,431,492	66
Total	1,095	100.0	11,375,987	100

¹ The figures for England and Wales refer to February 1924, those for Scotland to 31 December 1923 (number of societies) and 30 June 1922 (membership)

DISTRIBUTION OF FRIENDLY SOCIETIES WITH BRANCHES BY MEMBERSHIP ¹

Number of members	Societies		Branches		Membership	
	Number	Percentage of total	Number	Percentage of total	Number	Percentage of total
1- 1,000	4	7	4	0	2,027	0
1,001- 10,000	23	41	242	3	127,640	4
10,001- 50,000	12	21.5	448	6	247,982	8
50,001-100,000	12	21.5	696	10	864,976	26
100,001 and over	5	9	5,792	81	2,042,355	62
Total	56	100	7,182	100	3,284,980	100

¹ The figures for the approved societies in England and Wales relate to 31 December 1923, those for membership to 31 December 1918, the corresponding dates for the Scottish societies are 31 December 1923 and 30 June 1922 respectively.

Most of the persons affiliated to the centralised approved societies (66 per cent.) belong to a few important institutions, each with a membership of over 100,000, and only a small proportion (20 per cent.) belong to the many small societies representing over 60 per cent. of the total number. A similar disproportion may be observed in the case of the approved societies with branches.

The last table for Great Britain gives the number of friendly societies according as they insure only men or women or both

NUMBER OF APPROVED SOCIETIES INSURING EITHER OR BOTH SEXES ¹

Type of society	Societies and branches insuring only men	Societies and branches insuring only women	Societies and branches insuring both sexes
Centralised friendly societies	414	91	662
Friendly societies with branches	3,839	852	3,908
Industrial assurance and collecting societies	8	8	20
Trade unions	174	10	68
Employers' provident funds	40	4	64
Total	4,475	965	4,722

¹ ROYAL COMMISSION ON NATIONAL HEALTH INSURANCE: *Appendix to Minutes of Evidence*, Part I, pp. 70-71 London, 1924

The statistics in the tables for Great Britain do not cover approved societies in Northern Ireland. In this part of the country the number of international and national approved societies and their membership was as follows:

APPROVED SOCIETIES AND MEMBERSHIP IN 1925

Type of society	Number of societies	Membership
International		
Friendly societies	27	115,512
Trade unions	38	17,518
Industrial assurance societies	12	91,853
Employers' provident funds	2	7
National (for Northern Ireland)		
Friendly societies	21	96,896
Trade unions	4	1,673
Employers' provident fund	1	2,176

GREECE

Act No. 2,868 of 1923 provides for the institution of territorial funds (a Decree for their establishment has not yet been promulgated) and occupational funds. The latter may be formed either by trade unions (workers' organisation funds) or by employers (works funds and mining funds).

There exist at present 26 works funds with 18,852 members, one workers' pension fund with 15 members and one tobacco workers' insurance and protection fund with about 35,000 members.

HUNGARY

In Hungary, although the organisation of insurance is essentially territorial, there are also occupational and mutual benefit institutions.

The Hungarian system established by the Act of 1907 is a unified one from two points of view. In the first place, accident insurance and sickness insurance, the two existing branches of social insurance, are combined for administrative purposes, the National Workers' Insurance Fund being responsible for administering accident insurance and supervising the work of the sickness funds. The latter are similarly unified, the general type being the district fund, whose area corresponds to a political division of the territory. Within the general system, however, there are works funds founded by employers owning one or more undertakings in which a minimum number of workers are employed. During the Revolution the occupational funds were abolished (Order 21 of the Revolutionary Government), and only those works funds which had not been dissolved during this period were able to resume their activities after the promulgation of Order 3,679. There is also one mutual benefit fund within the framework of the general system.

During 1923 Order No. 9,210 laid down that every public railway undertaking should open a special fund for its employees liable to insurance, including retired employees and the widows and orphans of former employees. The administration of the post and telegraph services also has to set up a special fund for its staff, as also inland navigation undertakings (including ships' restaurants, loading and unloading, and shipbuilding). In principle these special funds are governed by the provisions of the 1907 Act, although they are outside the general sickness insurance system. Their formation explains the fall in the number of works funds during 1923 and 1924. In addition to these special funds outside the National Fund, there are also the Francis-Joseph Hospital Fund, which may be regarded as a special fund for commercial employees, certain tobacco factory funds, and the mining funds originally governed by Act No. XIV of 1891, which until 1922 undertook sickness insurance combined with disablement and accident insurance. Since the promulgation of Order 1,758 the mining funds, which are placed under the supervision of the Minister of Finance, have been subject to the provisions of the 1907 Act.

The Hungarian Act adopted the system of subsidiary compulsory affiliation, though different from that in force in Austria and Germany, as the principle of territorial grouping is more marked in Hungary than in the other two countries.

The employees of commercial undertakings in Budapest and Debreczen, where the two chief mutual benefit funds are situated, may be insured *en bloc* either in the mutual benefit institution or in the territorial fund.

All persons liable to insurance automatically become members of a workers' district fund unless they are already insured against sickness, in the manner and to the extent fixed by the law, with a works fund or a mining fund in operation in the area of the district fund (section 520, subsection 1). Any person employed in an undertaking for which a works fund has been formed may be notified to the fund by the employer unless the latter has already insured him in the district workers' fund (section 141, subsection 1).

Thus, under Hungarian law an insured person becomes a member either of a territorial or of an occupational fund, whereas under Austrian and German law persons liable to insurance may choose between a territorial fund and a mutual benefit fund. On the other hand, persons employed in undertakings for which special insurance institutions have been set up (transport undertakings, mines, postal and telegraph service, tobacco factories) cannot choose their insurer.

The number of sickness funds in operation within the general system¹ was as follows during the period 1919-1924:

¹ The statistics given do not relate to funds in operation outside the National Fund: the Francis-Joseph Hospital Fund, the railway funds, the post and telegraph fund, the inland navigation fund, the tobacco factory funds, and the mining funds.

NUMBER OF SICKNESS FUNDS

Year	District funds	Works funds	Mutual benefit funds
1919	38	25	2
1920	35	25	2
1921	35	26	1
1922	35	26	1
1923	35	23	1
1924	35	23	1

The next three tables show the membership of the different types of fund, the average membership of the funds, and the percentage distribution of the insured.

AGGREGATE MEMBERSHIP OF EACH TYPE OF FUND

Year	District funds	Works funds	Mutual benefit funds	Francis-Joseph Hospital fund
1919	473,911	38,070	6,639	41,890
1920	422,448	50,978	7,340	28,175
1921	497,870	65,102	1,083	35,376
1922	569,987	76,552	1,336	36,198
1923	638,356	28,390	1,542	40,746
1924	672,754	27,383	1,694	46,858

AVERAGE MEMBERSHIP OF EACH TYPE OF FUND

Year	District funds	Works funds	Mutual benefit funds	Francis-Joseph Hospital fund
1919	13,540	1,522	3,319	41,890
1920	12,081	2,039	3,670	28,175
1921	14,225	2,504	1,083	35,376
1922	16,285	2,944	1,336	36,198
1923	18,239	1,233	1,542	40,746
1924	19,222	1,191	1,694	46,858

PERCENTAGE DISTRIBUTION OF MEMBERS BY TYPE OF FUND

Year	District funds	Works funds	Mutual benefit funds	Francis-Joseph Hospital fund
1919	84.5	6.8	1.2	7.5
1920	83.0	10.0	1.5	5.5
1921	83.0	10.9	0.2	5.9
1922	83.3	11.2	0.2	5.3
1923	90.0	4.0	0.3	5.7
1924	89.8	3.7	0.2	6.3

There has been scarcely any change in the distribution of the insured during the years after the war. About 90 per cent. of the persons liable to insurance — a higher proportion than in Austria and Germany — belong to territorial institutions, and only 10 per cent. to occupational and mutual benefit funds.

IRISH FREE STATE

As the British Act is applied, subject to certain modifications, in the Irish Free State, the same types of institutions may be found in that country as in Great Britain¹. Nevertheless, the Act of 1911 (section 81, subsection 7) enabled the county councils in Ireland to establish societies for the insurance of persons living in the county. Several societies of this type have been set up, as well as others which insure only persons belonging to a certain religion or living in a certain diocese. There are at present 80 approved societies in the Irish Free State, 79 of which are centralised, while the remaining one has 20 branches. Of these societies 20 insure only men, one insures only women, and 59 insure both sexes. 62 of the societies insure only against sickness, while the remainder also insure against other risks. The number and membership of the different types of societies on 31 December 1923 are shown in the following table:

APPROVED SOCIETIES¹

Type of society	Number of societies	Membership	
		Number	Percentage of total
Diocesan societies	13	68,189	16.2
County societies	13	41,364	9.9
Trade unions	22	54,243	12.9
Friendly societies	18	164,391	39.1
Friendly societies with branches	1	11,585	2.8
Temperance societies	3	3,607	0.9
Industrial assurance societies	3	50,551	12.0
Railway provident funds	2	8,727	2.1
Employers' provident funds	5	5,287	1.2

¹ This table does not include the following special funds, the Deposit Contributors' Fund, the Military Forces Fund, the Exempt Persons' Fund, and the Irish Migratory Labourers' (Exempt Persons) Fund.

Thus in the Irish Free State, where the large majority of persons liable to insurance are insured in approved societies (the deposit contributors represent only 2.2 per cent. of the total liable to insurance), the friendly societies comprise the greater proportion of the insured.

ITALY (New Provinces)

According to the Legislative Decree of 29 November 1925, there are three methods of grouping the insured in the new Italian provinces. Insurance may be undertaken by the territorial funds, whose headquarters are at the chief towns of each district, or works funds, or mutual benefit funds. Any person liable to insurance who does not join a works fund or mutual benefit fund becomes a member of the territorial fund.

Decrees were issued by the Minister of National Economy on 30 April 1926 and 30 June 1926, the first empowering 24 territorial funds to act as insurers, the second 6 mutual benefit and works funds.

JAPAN

The Sickness Insurance Act of 22 April 1922 provides for the formation of occupational funds in undertakings employing 500 workers or more; such funds may be formed in undertakings employing 300 to 500 workers. All workers employed in an undertaking for which a works fund has been set up are bound to belong to the fund (section 25). Those employed in undertakings without a fund are insured by the State (section 24). For this purpose, provision is made for a State Insurance Office and 50 local offices.

LATVIA

The Sickness Insurance Code for workers and salaried employees issued in 1922 by the Codification Section of the Ministry of Justice provides only for the creation of works funds for one or more undertakings. Any undertakings employing more than 500 wage-earners and salaried employees may open a special works fund. If the number employed is below this figure a joint sickness fund is set up for the persons employed in several undertakings (sections 14 and 15).

All persons liable to insurance who are employed in an undertaking for which a sickness fund has been established belong to the fund. Membership begins on the day of admission to employment if a fund has already been established for the undertaking, and otherwise on the day when a fund is established for the first time or when the undertaking is affiliated to an existing fund (section 18).

The number of funds and their membership has been as follows during the period 1922-1926:

NUMBER AND MEMBERSHIP OF SICKNESS FUNDS

Year	Number of funds	Membership	Number of members' dependants
1922	—	46,408	—
1923	—	76,140	63,382
1924	41	105,840	83,297
1925	42	120,898	90,646
1926 ¹	42	139,830	93,575

¹ In December.

LITHUANIA

The organisation of the institutions defined in the new Lithuanian Act of 9 December 1925, amended on 28 September 1926, is based on the territorial principle. The law admits only of district sickness funds and their branches which may be formed by workers in undertakings employing not less than 150 persons.

A similar provision is in force in the Memel territory. The Order of 18 November 1922 concerning the reorganisation of social insurance in that territory provided for the creation of an Insurance Office (*Landesversicherungsanstalt*) as the sole statutory insurer against the risks covered by the German Insurance Code of 1911 (amended), the Employees' Insurance Act, and unemployment insurance. The work of the Office is carried out through four local branches, one for each division of the territory. According to the Order of 28 December 1923 concerning the reorganisation of social insurance in the Memel territory, agricultural employers may, however, exempt from sickness insurance any of their workers, salaried employees, apprentices or domestic servants in their permanent employment by notifying the Insurance Office. In this event they must grant the persons employed by them in virtue of a contract of service the sickness benefits specified by the Order of 28 December 1923 concerning the relief of agricultural wage-earners.

Neither in Lithuania properly so called nor in the Memel territory have insured persons the right to choose their insurer. Both laws accept the principle of compulsory affiliation.

LUXEMBURG

The sickness insurance system introduced by the Act of 31 July 1901, amended on 9 February 1918 and 8 March 1919, provided for territorial, occupational and mutual benefit institutions. It was reorganised by an Act of 17 December 1925 which abolished the mutual benefit funds, chiefly owing to their unsatisfactory financial situation during the period 1918-1923.

The new Act entrusts the administration of insurance to territorial institutions, one for each division of the country, and occupational institutions formed by the employers of undertakings with not less than 500 workers. When an employers' fund has been set up for an undertaking, all persons liable to insurance who are employed in the undertaking must belong to it (section 28). Persons liable to insurance who are not members of a workers' fund belong to the territorial fund for the district in which they are employed.

The three tables below contain particulars of the number and membership of the Luxembourg funds in 1913 and from 1919 to 1923. The first table shows the total number of funds and their average membership irrespective of the type of fund.

NUMBER OF FUNDS AND AVERAGE MEMBERSHIP

Year	Number of funds	Average membership per fund
1913	59	746
1919	56	674
1920	53	723
1921	52	738
1922	52	837
1923	50	943

The next table shows the number of funds of each type: territorial, occupational and mutual benefit.

NUMBER OF FUNDS, MEMBERSHIP AND AVERAGE MEMBERSHIP IN
EACH TYPE OF FUND

Year	Regional funds			Industrial funds			Mutual benefit funds		
	Number of funds	Total membership	Membership per fund	Number of funds	Total membership	Membership per fund	Number of funds	Total membership	Membership per fund
1913	14	17,462	1,247	41	25,997	634	4	581	145
1919	14	13,010	929	38	24,162	636	4	547	137
1920	14	14,855	1,061	35	23,053	659	4	534	133
1921	14	16,232	1,159	34	21,605	600	4	522	130
1922	14	18,454	1,318	34	24,561	682	4	499	125
1923	14	21,378	1,527	32	25,341	792	4	455	114

The table shows that there was no change in the number of territorial and mutual benefit funds, and that the average membership of the regional funds rose. There was a marked reduction in that of the mutual benefit funds. During the period under consideration there was a substantial reduction in the number of industrial funds due to their dissolution or amalgamation, but their average membership rose.

The third table gives the distribution of the insured by type of fund.

PERCENTAGE DISTRIBUTION OF MEMBERS BY TYPE OF FUND

Year	Regional funds	Industrial funds	Mutual benefit funds
1913	39.7	59.0	1.3
1919	34.5	64.0	1.5
1920	38.6	60.0	1.4
1921	42.3	56.3	1.4
1922	42.4	56.4	1.2
1923	45.3	53.7	1.0

NORWAY

The Norwegian Sickness Insurance Act of 6 August 1915 provided for the establishment in every commune of a territorial fund (district funds). In addition, occupational funds (works funds and trade union funds) may be formed which under certain conditions may take the place of the district funds. There are also occupational substitute funds for teachers and railway employees, although they are not subject to the Act.

Any person liable to insurance may choose between the territorial fund and an occupational fund where such are in existence. According to section 7 of the Act persons liable to insurance must be insured either in the public fund for their district or in an approved fund (communal fund, trade union fund, works fund), or finally in a substitute fund (teachers' fund, railwaymen's fund). Unless the insured person's place of work is situated in a commune which has set up a communal sickness fund, he cannot choose his insurer if he is employed in an undertaking for which a works fund has been set up or belongs to a trade union with a trade union fund or an occupation to which a special insurance institution applies.

In principle an employers' fund must cover all the persons employed in the undertaking who are liable to insurance (section 54, subsection 3). But no person who can prove that he has fulfilled his obligation to insure by joining a district fund or other approved sickness fund can be compelled to join a communal fund or employers' fund (section 58).

Members of a trade union fund who are liable to insure must continue to belong to the fund as long as they belong to the trade union to which the fund is attached (section 54, subsection 4).

The total number of sickness insurance funds in Norway was 962 in 1924. The majority, or 734, were district funds, of which 62 were urban funds. The approved funds, of which there were 71 in 1916, have fallen steadily in number, to 55 in 1920 and 43 in 1924. There were 180 teachers' funds in 1924 and 5 railwaymen's funds.

The following table gives the membership of the district funds and approved funds during the period 1912-1925.

AGGREGATE MEMBERSHIP OF EACH TYPE OF FUND

Year	District funds	Approved funds	
		Membership	Percentage of district fund membership
1912	330,000	31,100	9.4
1913	337,620	32,947	9.8
1914	340,619	34,240	10.1
1915	351,217	36,969	10.5
1916	429,878	42,700	9.9
1917	473,439	45,860	9.7
1918	520,657	29,746	5.7
1919	543,124	29,454	5.4
1920	558,661	25,969	4.6
1921	548,250	22,281	4.1
1922	570,524	21,611	3.8
1923	579,314	14,555	2.5
1924	584,800	14,531	2.5
1925	596,184	14,911	2.5

The table brings out the opposite tendencies of the two sets of figures. The rising tendency in the membership of the district funds may be contrasted with the constant fall in the membership of the approved funds since the Sickness Insurance Act of 6 August 1915 came into force. Whereas in 1916 the membership of the approved funds was 9.9 per cent. of the membership of the district funds, the proportion fell to 2.5 per cent. in 1925.

With the figures given above, the following table, showing the average membership per fund, has been constructed:

Type of fund	Average membership
Urban district funds	1,362.0
Rural district funds	167.8
All district funds	796.7
Approved funds	337.9
All sickness funds (district and approved)	771.3

POLAND

Except in Upper Silesia, where the non-territorial funds in existence when the territory was transferred to Poland have been maintained, the organisation of insurance is essentially territorial. The Act of 19 May 1920 provides for a sickness fund in each district, and a special fund in every town with a population of over 50,000, such funds also being territorial in character. Only the workers on the State railways, owing to the special conditions of their work, are insured in occupational funds.

Under the Act insurance in a territorial fund is compulsory for all persons covered by the Act whose regular place of work is situated in the area of the fund (section 5, subsection 1) ¹. The fact of being insured against sickness with any other society does not exempt from the obligation to become a member of the territorial sickness fund (section 5, subsection 2).

Before the Polish State was created there were in the territory of former Galicia (then Austrian territory) 189 sickness funds of various types, with 185,253 members. On former Prussian territory there were on 1 January 1913 about 250,000 insured persons in several hundred sickness funds of various types. In former Russian territory, on the contrary, no insurance system had ever been in force. These differences between the three parts of Poland led the legislature to adopt a system based on the political idea of unification.

For the former Prussian and Austrian territory the work of organisation may be considered practically finished. For former Russian territory the idea was to set up sickness funds in the first place in industrial districts and then in other districts with a less dense wage-earning population. The realisation of this plan met with obstacles owing to the very difficult position of the country after the war, but some of these have been overcome. The organisation of funds in agricultural districts is closely connected with the extension of compulsory insurance to agricultural workers, who in certain parts of the country are not yet liable to insurance.

The following table gives particulars of the number of funds in the various parts of Poland at the beginning of 1925.

NUMBER OF FUNDS AT THE BEGINNING OF 1925

Territory	Number of funds	Number of administrative districts	Number of funds established per cent. of number required by law
Former Austrian territory	71	85	100
Former Prussian territory	57	53	100
Former Russian territory	47	119	39
Upper Silesia	47 ¹	—	100
Total. . . .	222	257	—

¹ Until the unified insurance system for the whole of Poland has been introduced, the 47 Upper Silesian funds are subject to the former German law as amended by the Silesian Diet.

¹ The Act defines as "the place of work" the place where the insured person is permanently employed, even if for the time being he ceases to work there and carries out tasks of short duration at his employer's order outside the area of the fund.

For persons who have no fixed place of employment the place of work is deemed to be that in which the undertaking is situated. For those who are employed in different communes by the management of an undertaking, the commune in which the office managing the actual works is situated is deemed to be the place of work (section 9)

A more detailed survey of the organisation of sickness funds in industrial and agricultural districts is given in the following table

NUMBER OF SICKNESS FUNDS IN DIFFERENT REGIONS¹

Territory	Region	Organised funds	Funds being organised	Number of administrative districts	Organised funds, per cent. of statutory number
Former Prussian territory	Poznan	37	—	35	100
	Pomerania	20	—	18	100
Former Austrian territory	Cracow	18	—	23	100
	Leopol	25	—	27	100
	Tarnopol	13	—	17	100
	Stanislawow	13	—	16	100
	Austrian Silesia	2	—	2	100
Former Russian territory	City of Warsaw	1	—	1	100
	Warsaw	10	5	23	100
	Lodz	13	—	13	100
	Kielce	11	4	16	69
	Lublin	3	3	19	16
	Bialystok	5	4	13	38
	Wilno	2	—	7	28
	Polesia	—	3	10	—
	Wolhynia	3	—	10	30
	Nowogrodek	—	—	7	—

¹ *Przegląd Gospodarczy*, 1925, No.24, p. 1,444.

Thus the degree of organisation differs considerably from one region to another, the network of funds being complete in the industrial parts of the country but not yet finished in the eastern agricultural districts.

The system of territorial organisation and compulsory affiliation adopted in Poland has the advantage of sufficiently large funds. This will appear from the following table, giving the distribution of the funds by membership at the end of 1924.

DISTRIBUTION OF FUNDS BY MEMBERSHIP AT THE END OF 1924¹

Membership	Former Austrian territory	Former Prussian territory	Former Russian territory	The whole of Poland
Under 1,000	4	—	9	13
1,000-3,000	27	2	14	43
3,000-5,000	15	6	4	25
5,000-10,000	18	39	8	65
10,000-25,000	4	9	8	21
25,000-50,000	3	—	1	4
50,000-100,000	—	1	1	2
Over 100,000	—	—	2	2
	71	57	47	175

¹ *Przegląd Gospodarczy*, 1925, No. 27, p. 1,446.

The largest group is that of funds with a membership of 5,000 to 10,000. The institutions with less than 2,000 members, a figure below which it is difficult for one fund alone to organise adequate medical service, constitute only about 20 per cent. of the total number.

The average membership per fund, which is relatively high, was as follows for the different parts of the country at the end of 1924.

AVERAGE MEMBERSHIP PER FUND IN DIFFERENT
PARTS OF THE TERRITORY

Territory	Average membership
Former Austrian territory	5,889
„ Prussian „	8,789
„ Russian „ (excluding city of Warsaw)	10,130
City of Warsaw	190,494
Upper Silesia	4,568
All Poland	8,106

PORTUGAL

According to Decree No 5,636 of 10 May 1919 on compulsory sickness insurance, the management of the system is entrusted to regional mutual benefit institutions organised on the model of the voluntary mutual benefit societies for sickness. Such institutions must be set up in all districts on the mainland and the adjacent islands (section 2). At Lisbon and Oporto there may be up to six compulsory mutual benefit institutions in each quarter (section 2, subsection 2). The Decree also provided that the three associations in existence on the date of its promulgation should be transformed into compulsory institutions (section 87). It allowed the continued existence of such free mutual benefit societies as did not transform themselves into compulsory institutions (section 14) and maintained the right to set up new mutual benefit societies (section 82).

Persons liable to insurance must be registered by the parish committees (*Juntas*), which must send in a report on their operations to the municipal authorities within 60 days (section 5).

ROUMANIA

Former Kingdom and Bessarabia

The Act of 25 January 1912 on the organisation of crafts, credit, and social insurance, which was extended to Bessarabia by the Act of 9 April 1924, provides for the creation of brotherhoods consisting of at least 25 artisans in the same trade (section 64). Several brotherhoods may combine to form a guild, which must consist of not less than 1,000 members, and constitutes the primary insurance institution (section 78). Manual labourers, workers who are not artisans, or have had no vocational training, if employed in factories, quarries, or other industrial undertakings, cannot belong to a brotherhood, but form part of the guild (section 2, subsection 2).

In addition to the system grouping the insured in craft guilds, there are free mutual benefit societies and benefit funds for the administrative departments (sections 136-139).

Nevertheless, both the guilds and the mutual benefit societies serve merely as branches of the single insuring authority, the Central Workers' Insurance Office at Bucarest. The contributions of all the insured, whether they belong to a guild or to a mutual benefit society, are collected, by a system of stamps, for the Central Insurance Office, which in return provides the guilds with

the necessary sums for the payment of sickness insurance benefit (section 195, subsection 4) Sickness insurance may thus be said to be centralised by the Bucarest Central Office.

The affiliation of the insured is in principle compulsory, because every person carrying on one of the trades covered by the Act is bound to belong to a brotherhood or guild (sections 64 and 65) Only the workers in administrative departments and the industrial undertakings for which mutual benefit funds have been set up are entitled to choose their insurer (section 136).

Ardeal

In this part of Roumanian territory the Hungarian Act XIX of 1907 (amended) has been kept in force The territorial funds governed by it are directly attached to the Central Workers' Insurance Fund at Bucarest.

Bukovina

Here the former Austrian Act of 30 March 1888, as amended until the end of 1918 and subsequently, has been maintained There are at present 14 sickness insurance institutions in Bukovina, of which ten are district funds, three works funds, and one a commercial employees' fund.

RUSSIA

Insurance is organised on the territorial and unified principle, the same institutions being responsible for insurance against all physical risks as well as the economic risk of unemployment

The primary institution is the local fund, organised by the departmental or regional social insurance authorities for the area within a radius of two versts of the centre of each district, provided that the membership is not less than 2,000. In administering insurance, such funds may make use of two sorts of local organs, insurance offices or commissioners. These local authorities are set up in distant places wherever the number of insured is insufficient for the organisation of an independent fund The offices are set up in districts or undertakings covering 200 to 2,000 workers, and commissioners are appointed for districts or undertakings covering 50 to 200 persons In both cases the undertaking or institution in question must be more than five versts distant from an insurance fund

The only exception to the territorial principle is for workers employed on water transport or the railways, or in railway construction. The existence of occupational insurance institutions is due to the particular conditions under which these workers live, as they are scattered along the railway lines and inland waterways, being more closely connected with the centre from which the transport is organised than with the departmental centres where the territorial insurance funds are set up The local social insurance organs for transport workers are the main line insurance funds for the railways, and the divisional insurance funds for the inland waterways The latter are subdivided into district insurance funds, which may set up insurance offices or appoint commissioners like the territorial funds

Any person liable to insurance must be automatically affiliated by his employer with the competent fund for the insurance of workers in the undertaking The worker may be insured directly by the fund, or through the medium of one of its local organs (insurance office or commissioner) if he is employed by an undertaking for which an insurance office or commissioner is competent.

Particulars are given below of the number of territorial funds in the different parts of the Union of Socialist Soviet Republics in 1924, 1925, and 1926.

NUMBER OF TERRITORIAL FUNDS

	1924 ¹	1925 ²	1926 ³
R S F S R.	476	458	432
Ukraine	97	72	43
White Russia	10	10	—
Total (U S S R)	634	593	546

¹ On 1 October 1924² On 1 January 1925³ On 1 January 1926

Thus the number of funds was considerably lower in 1926 than in 1924, a reduction which may be ascribed largely to the amalgamation of several small funds. During the same period one may observe a constant increase in the number of insurance offices (from 782 in October 1925 to 941 in July 1926) and of commissioners (from 1,090 in October 1925 to 1,299 in July 1926).

The following table gives the distribution of the funds in the Union by membership in 1924, 1925, and 1926.

DISTRIBUTION OF TERRITORIAL FUNDS BY MEMBERSHIP (ABSOLUTE FIGURES)

Membership	Number of funds		
	1924 ¹	1925 ²	1926 ³
Under 2,000	166	146	89
2,000 — 3,000	98	87	55
3,000 — 5,000	150	109	91
5,000 — 10,000	106	120	130
10,000 — 20,000	70	81	94
20,000 — 30,000	16	20	37
30,000 — 40,000	14	11	24
Over 40,000 . .	15	19	31
Total	634	593	551

¹ On 1 October 1924² On 1 January 1925³ On 1 July 1926

DISTRIBUTION OF TERRITORIAL FUNDS BY MEMBERSHIP (PERCENTAGES)

Membership	Percentages		
	1924 ¹	1925 ²	1926 ³
Under 2,000	26.1	24.6	16.2
2,000 — 3,000	15.3	14.7	10.0
3,000 — 5,000	23.5	18.4	16.5
5,000 — 10,000	16.7	20.2	23.6
10,000 — 20,000	11.3	13.7	17.0
20,000 — 30,000	2.5	3.4	6.7
30,000 — 40,000	2.2	1.8	4.4
Over 40,000 .	2.4	3.2	5.6

¹ On 1 October 1924² On 1 January 1925.³ On 1 July 1926.

These figures, which relate to only three years, indicate an increase in the number of large funds as compared with smaller ones

The average membership of the funds, which was only 5,210 in 1923, rose (for the territorial funds) to 6,936 on 1 July 1924, and 8,036 on 1 October 1924. In July 1925¹ it was 11,500, and a year later 13,227. This average varied considerably from one region to another. Thus, in 1923 it was 3,200 in the autonomous provinces (Votjak, Karelia, Mari, etc.) and 6,500 in Central Russia.² In 1924 it ranged from 2,500 to 3,671 in Daghestan and Kirghiz; it was 10,859 in the Ukraine, and 13,654 in Moscow.³

The figures for Russia, like those for Poland and the Serb-Croat-Slovene Kingdom, suggest that in States where agriculture predominates and which have adopted the system of territorial grouping and compulsory affiliation, the average membership of the funds is particularly high in urban centres, and falls according as the distance from such centres increases. Where means of communication are difficult, institutions whose territorial competence is very wide cannot reach all the insured, and must give way to smaller organisations.

SERB-CROAT-SLOVENE KINGDOM

According to the Act of 14 May 1922, there is only one institution for insurance against the risks of sickness, invalidity, old age and death, and accidents, the Central Workers' Insurance Institution. This central institution, although by law the only insurer and financial unit, has to work through local offices. Of these there are 23, based on the territorial principle (local workers' insurance institutions). In addition, special funds attached to the Central Institution have to be set up for workers in transport undertakings which cover the districts of several local institutions and employ not less than a thousand persons subject to the Act.

Outside the Central Institution there are occupational funds for miners, which may be set up in mining undertakings employing not less than 2,500 workers. There are also two mutual benefit funds which were maintained when the 1922 Act came into force (articles 111 and 176 of the rules of the Central Workers' Insurance Institution): the Mutual Benefit Fund "Merkur" at Zagreb and the Private Employees' Sickness Fund at Ljubljana.

Insured persons establish their claims and fulfil their obligations through the medium of the territorial institution for the district in which the undertaking employing them is situated. The competent district institution for ships' crews is that for the district in which the port of register of the ship is situated. Workers in transport undertakings and mines are compulsorily affiliated to the particular occupational funds concerned.

As the organisation of insurance is thus in essence territorial, and the principle of compulsory affiliation is strictly enforced, there can be no question of comparing the various types of institutions. At the most it is possible to examine which local offices work under the more favourable conditions. In this connection it should be remembered that the membership of a local institution is not the only deciding factor, but that their work is also affected by the size of the insurance district, means of communication, etc. In the following table the absolute and relative membership of the local offices for the administrative sub-divisions of the Central Institution is shown for 1924, the first year of normal working.

¹ *Insurance Questions*, 1926, No. 16, p. 4.

² Calculated from data in the publication *Social Insurance*, 1923, p. 184.

³ *Social Insurance in 1924 to 1925*, p. 10.

MEMBERSHIP OF LOCAL WORKERS' INSURANCE INSTITUTIONS IN 1924

Local institutions (territorial divisions and special funds)	Membership	Membership per cent. of total insured
Banja Luka	21,090	4.59
Belgrade	62,213	13.54
Bjelovar	12,146	2.64
Brod on the Save	10,823	2.36
Dubrovnik	9,133	1.99
Karlovac	12,575	2.74
Ljubljana	74,333	16.17
Mostar	5,009	1.09
Novi Sad	15,630	3.40
Osijek	31,034	6.75
Sarajevo	18,215	3.97
Sombor	19,649	4.27
Split	17,961	3.91
Subotica	19,659	4.28
Susak	6,605	1.44
Travnik	7,979	1.73
Tula	5,092	1.11
Varazdin	12,596	2.74
Veliki Beckerek	17,453	3.80
Vrsac	12,350	2.69
Zagreb	42,661	9.28
Zemun	13,131	2.86
"Merkur" private employees' fund	8,372	1.82
Ljubljana private employees' fund	3,802	0.83
Central Workers' Insurance Institution	459,511	100.00

SWITZERLAND

Under the Federal Act of 13 June 1911 the Cantons may make sickness insurance compulsory for all or certain groups of persons, and it empowers them for this purpose to set up public funds, due account being taken of existing benefit funds (section 2). Five Cantons (Appenzell, Outer Rhodes; Appenzell, Inner Rhodes; Basle Town; St. Gall; and Thurgau) have made use of these powers. While maintaining the existing private funds, these Cantons have established public funds on a territorial basis to supplement them. In Basle Town and Appenzell (Inner Rhodes) public sickness insurance funds have been opened, one in the first and two in the second. In St. Gall, each commune is bound to open a communal sickness fund. In the Canton of Appenzell (Outer Rhodes), the communes, which are not obliged to set up public funds, may undertake sickness insurance by concluding agreements with existing recognised sickness funds. In the Canton of Thurgau, sickness insurance is put into effect if possible by agreements with existing funds, only if this is impossible must a public fund be established. In these five Cantons any insured person who has not voluntarily joined a fund recognised and subsidised by the Federal Government becomes a member of the public cantonal or communal fund.

CHAPTER II

FORMATION AND MACHINERY OF INSTITUTIONS

§ 1. — Formation and Recognition

The problem of the formation of insurance institutions varies according as the system is managed by the State or is entrusted to independent bodies managed by the persons concerned.

When insurance is managed by the State, it alone takes the initiative in the creation of the institutions. These are formed in the same conditions as those of any other public service, the law entrusting the work of organisation to an administrative authority, which in carrying out this work may make use of its subordinate local organs. Thus the Russian Act of 31 October 1918 entrusted the duty of organising the All-Russian Social Insurance Fund to the Social Insurance and Labour Protection Department of the Commissariat of Labour and its local organs, the social insurance and labour protection departments in the local councils. Similarly, the Bulgarian Act of 6 March 1924 instructed the Minister of Commerce, Industry and Labour to set up in the Labour Department a special insurance office with powers to create the Social Insurance Fund, in collaboration with the factory inspectorates, and with the support of the municipalities.

Even if the management of insurance is in the hands of independent institutions administered by those concerned, the public authority must see to it that every insured person is able to find an insurer. Whatever the method of grouping the insured and the system of affiliation to the institutions, the State must make up for any omissions on the part of those concerned when the constitution of the funds is in their hands. Thus, in systems of sickness insurance with mutual benefit societies and free affiliation (Great Britain) the public authorities set up bodies for administering the moneys derived from the payments of those persons who have not chosen an insurer. Similarly, they intervene when the insurance system is that of trade funds, if the funds have not been formed in time. Finally, in countries where the law provides for several types of institution side by side, with subsidiary compulsory affiliation,

the authorities organise territorial funds for persons liable to insurance who have not joined a mutual benefit society or trade fund.

So long as the administration of insurance is entrusted to institutions in existence when insurance was made compulsory, there is of course no question of initiative for the creation of insurance institutions. The problem arises only if new bodies (mutual benefit societies, trade funds, territorial funds) are made responsible for the management of insurance, either alone or in competition with existing institutions.

The formation of new mutual benefit societies is left to the free initiative of those concerned, the State intervening only to grant the recognition or approval required under the law. The formation of trade funds (works funds, guild funds) may be entrusted either to the insured (Esthonia and Latvia), or to employers (Austria, Germany, Greece, Hungary, Japan), who in some cases are required by law to consult the workers concerned (Germany, Japan). Finally, in special insurance systems where the institutions are occupational, the initiative for creating the funds usually lies with the public authorities (miners' insurance in Czechoslovakia and Germany, seamen's insurance in Belgium and France). The supervisory authorities do not intervene in the creation of trade funds unless affiliation to such funds is compulsory (Esthonia, Latvia, Japan) and the employer fails to take the necessary action within the specified period. This applies also to the building funds for a certain number of temporary workers (Austria, Germany) and works funds for workers who are particularly exposed to the risk of sickness (Austria).

Territorial funds are usually constituted by the central administrative authorities and their agents (Central Social Insurance Institution in Czechoslovakia, National Insurance Fund in Hungary, Superior Social Insurance Office in Lithuania, Ministry of Labour and Social Assistance in Poland), or the local authorities (regional authorities in Austria, federations of communes in Germany, communes in Norway), or local insurance authorities acting in collaboration with the trade union organisations (Russia). These authorities arrange for the establishment of territorial institutions, either by appointing the members of the provisional committee or by organising the elections for the first constituent meeting. Whatever the origin of a sickness fund and the method of grouping the insured, it cannot administer compulsory insurance unless it has been duly recognised and approved by the competent authorities. By making insurance compulsory the State compels employers and workers to pay

contributions, and it is therefore its right and duty to make the recognition of the funds dependent on its approval of their rules and their acceptance of regulations concerning financial stability and good management. In point of fact, the insurance laws establish the general principles of the system, fixing its scope, the manner of procuring funds, the minimum contributions, and the main regulations concerning administration and the settlement of disputes. Except where insurance is administered by the State, each institution is made responsible for adopting detailed regulations in application of the general system, in accordance with the interests of the group concerned. The rules of the fund, which are thus fitted into the framework of the general regulations, constitute the internal legislation for the group. A preliminary examination of the rules enables the competent authorities to ascertain if they contain any provisions contrary to the legislation in force.

In the first place, the State very generally demands that a body which proposes to engage in social insurance shall give up any other activity incompatible with the object of such insurance, and prohibits it from doing any business for profit. It may also recognise only those funds which already have a sufficient reserve fund, or whose rules provide for the constitution of such a fund within a certain period. In view of the fact that the risk is more easily borne in large institutions, and that small funds may fail if the morbidity rate rises above the level estimated when the fund was formed, the law often lays down the right of the State to approve only institutions with a minimum membership.

If it is proposed to make mutual benefit institutions statutory insurers side by side with territorial or trade funds, the usual tendency is for the law to recognise only institutions whose operations do not interfere with neighbouring groups. The reason is that it may be feared that a mutual benefit fund will limit its right of admission in such a way as to make a particularly favourable selection of risks, thus compelling the other institutions, especially the territorial funds, to accept members with a particularly high risk of morbidity. For this reason the funds are often prohibited from refusing to admit persons for reasons of age or health.

Finally, in order to ensure the regular working of the institution and to prevent disputes, the law requires that the rules should contain certain provisions as to the administrative bodies, their composition, powers, and method of appointment.

§ 2 — Management

STATE MANAGEMENT

When the State itself is responsible for the administration of the system, the law must specify an administrative service which is to be the institution responsible for the collection of contributions and the distribution of benefits in cash and in kind. As compulsory sickness insurance is considered by the State in the light of a public duty, it might be supposed that the State alone would have sufficiently powerful means of completely fulfilling the aims of insurance, and giving the system the necessary uniformity and extension. If all the insured are grouped in a single institution or a network of linked institutions, a better compensation between the various risks might be expected. In certain countries where free insurance is not developed and the organisations of workers and employers are so weak that they could not undertake the management of independent institutions, this system obviously has its advantages. Be this as it may, only a very small number of cases in which these principles have actually been put into practice can be quoted.

The insurance system¹ introduced in Russia by the Act of 31 October 1918 at the time of the transition to the Communist regime is in certain respects similar to that indicated above. This Act set up an All-Russian Social Insurance Fund, whose resources were derived from the contributions of private and State undertakings and independent workers, and which was administered by the Department for Social Assistance and the Protection of Labour in the People's Commissariat of Labour and by its local organs. From 28 February 1919, however, the local management was entrusted to the bodies designated by the local trade union federations. As at that date the Soviet Government had adopted a systematic policy of the nationalisation of industry and commerce, the Decree of 17 April 1919 modified the financial and administrative system set up by the Act of 31 October 1918, by abolishing the obligation for State undertakings to contribute to the All-Russian Insurance Fund, and setting up instead a complete system of relief out of State resources.

¹ In the original text the Act is entitled 'Act for the Social Assistance of the Workers.'

At the present date Bulgaria alone has a general system of insurance in which the State is responsible for the administration.

All wage-earners and salaried employees are bound to insure with the Social Insurance Fund, which is managed by the Ministry of Commerce, Industry, and Labour. The insured and their employers, who contribute to the resources of the fund, are thus deprived of any direct participation in its management. In Japan the system of State management is only partly applied.

Among special systems, reference may be made to the Swiss insurance of service men administered by the Federal Government¹.

Whatever the motives which gave rise to the above laws, their limited number suggests that it is only by way of exception that the modern State chooses the system in which the management of compulsory sickness insurance is in the hands of the administrative authorities. The chief reason for this attitude is the fear of creating a new and vast public service with thousands of officials, who will be accused of lack of initiative and subjection to bureaucratic routine. In this, as in so many other fields of economic and social activity, the tradition is that the State is a slow and costly administrator. There is also the desire to make the insured participate in the working of the system so as to keep alive a sense of responsibility and to prevent abuses by means of their mutual supervision of each other for the protection of the institutions in whose prosperity they are directly interested.

The risk of costly financial management in a system of State insurance was recently brought out in the memorandum submitted in 1924 by the Irish Health Insurance Commissioners to the Committee on Health Insurance and Medical Services²:

If the State took over the responsibility for administering Health Insurance, it would be difficult, if not impossible, to prevent the public from thinking that there was a State guarantee behind the scheme and that, should a deficiency arise, the State would have to make it good. The consequence would be the risk of increasing the sums needed for the payment of benefits, owing to the tendency to consider the insurance fund as a "public fund", and to draw on it more liberally. The cost of the necessary supervision to protect the fund would then become prohibitive³.

¹ HANS GIORGIO. "Die Organisationsformen in der Sozialversicherung." *Schweizerische Juristen-Zeitung*, No. 17, 1 March 1921. Lucerne.

² SAORSTAT EIREANN. *Appendices to the Interim Report of the Committee on Health Insurance and Medical Services*, p. 26. Dublin.

³ The argument against the State management of insurance contained in the Irish report was also put forward during the discussion on the French Bill, which nevertheless provided for the creation of independent institutions. The

In fact, nearly always insurance is managed by independent bodies, the State merely reserving the right to exercise supervision over their work, whether they are private insurance companies, mutual benefit funds, trade funds, or territorial funds.

PRIVATE COMPANIES

There is no country where the management of compulsory sickness insurance is entrusted to private insurance companies. The object of such companies is to make a profit, and it would seem that they can carry on their work only at the expense of the insured. The idea of profits cannot be reconciled with the care for public health, and in most cases the insured will be unable to count on benefits in excess of the statutory minimum. The commercial methods of the companies mean that they spend part of their resources on advertisement, and thus the management of insurance tends to become too costly. They give the insured and employers no chance of participating in the management of the funds they accumulate. Even with insurance companies on a mutual basis, any form of democratic management is impracticable because of the large number of members they have to recruit. In this way compulsory insurance, which, in the intention of its promoters, is to be a powerful training in self-government for the millions of wage-earners, loses a large part of its social educational value.

Nevertheless, in Great Britain a number of private insurance companies participate indirectly in the administration of compulsory insurance by creating mutual benefit societies side by side with branches of insurance run for profit.

SELF-GOVERNMENT

Self-government by the parties concerned is the method of administration most often adopted for sickness insurance. With the exception of the Bulgarian Social Insurance Fund and the

memorandum submitted to the Senate by Mr. Jacques Duroux, on behalf of the Committee for Commerce, Industry, Labour, and the Postal Service (*Senate*, No. 182, 1926, p. 109), contained the following passage: "Its [the Act's] financial danger lies in the fact that it recognises the formal and unlimited right of the insured to claim and obtain in full the payment of all social insurance benefits as soon as they fulfil the statutory conditions to which the establishment of the claim is subject. If at a given moment the resources of the insurance funds, including the General Guarantee Fund, are not enough to meet the legal obligations, the State will be legally bound to make up the balance

Japanese health insurance offices, all the institutions of compulsory sickness insurance are managed by the parties concerned, viz, the insured and their employers, to whom are sometimes joined representatives of public authorities.

A justification of the management of the insurance institution by the insured lies in the view that the contributions both of workers and of employers are only a form of wages, over which the workers should have the right of disposal. Another reason is that the persons ultimately benefiting by the insurance are directly interested in the satisfactory working of the organisation and especially in its financial stability, on which the regular covering of the risk depends. Because of this interest the participation of the workers in administering the institutions helps to increase their sense of responsibility. It makes it possible to establish proper mutual supervision, which may be wanting in a purely bureaucratic organisation. Moreover, the workers are often in the best position to know their social conditions, so that by taking part in the work of the administrative bodies of the funds full allowance may be made for the needs of the insured. Finally, this participation promotes a knowledge among the workers of sickness insurance and hygiene and facilitates preventive measures. From a more general point of view it is one of the best trainings for democracy.

The employers' participation in management is generally justified by the same argument with respect to contributions. It is contended that the employer, by paying part of the sums out of which, the insurance funds are accumulated, has the right to a fair representation on the deliberative, executive, and supervisory bodies. It is his only means of supervising the use made of the funds which he has helped to accumulate. It is the opinion of employers that the sums they pay affect their profits and still more their costs, thus giving them a right to share in the administration of the institutions. Moreover, they consider that they represent in the funds an element of restraint which tends to prevent bad management and waste.

The representatives of the authorities may intervene in the management of insurance institutions as an impartial factor to keep the balance between the employers' and workers' delegates.

They represent general interests, for the community also shares in the costs of insurance, either directly (State contributions) or indirectly by the transference of the incidence of insurance costs. Moreover, they may contribute to the regular working of the institution by providing expert technical assistance.

CLASSIFICATION OF LAWS ACCORDING TO METHODS OF MANAGEMENT

The principles on which management is shared between these three factors are far from uniform in every country. The provisions of the different laws have usually been the result of the particular balance of the forces of occupational, political, and mutual benefit organisations when the law was framed. Sometimes more or less allowance has been made for the share in costs met by the insured, employers, and the State. Finally, the law may have been modelled on the compulsory insurance system already in force in another country.

From this point of view the different laws may be divided into four groups: (1) management by the public authorities; (2) management by the insured; (3) management by insured and employers; and (4) management by insured, employers, and representatives of the authorities.

Group (1). — The Bulgarian system is administered by State officials and so is part of the Japanese system also. In Bulgaria the employers and insured participate in the management of sickness insurance only through the medium of their representative on the arbitration court, which settles disputes connected with medical attendance and cash benefit, and through their delegates to the central advisory institution, the Superior Labour and Social Insurance Council.

Group (2). — The insured alone administer the institutions in Esthonia, Great Britain, Irish Free State, Latvia, Portugal, Russia.

In Great Britain and the Irish Free State, where insurance is in the hands of mutual benefit societies, whether those already in existence when insurance was made compulsory or newly-created bodies, the insured are in principle alone responsible for administration, the employers being represented only on the authorities of certain works funds. In Esthonia and Latvia the general meeting and managing committee of the funds consist only of delegates of the insured workers. Employers may be represented only on the audit committee. In Portugal the management of insurance is entrusted to the compulsory mutual benefit societies, on whose administrative bodies only the insured are represented. The

Soviet law provides that the social insurance funds are to be administered solely by wage-earners.

Group (3). — Most laws provide for the management of the institutions by both employers and insured.

Some establish a close connection between the proportion of employers' and workers' votes in the administrative bodies and the share of these two groups in the cost insurance (Austria, Germany, Hungary, Japan, Luxemburg, Serb-Croat-Slovene Kingdom). In others no definite relation is fixed (Czechoslovakia, France for miners' insurance, Greece, Lithuania, Norway, Poland).

The law may either give the employers and insured an equal vote in the administrative bodies of the funds, or permit either interest to play a predominant part. The two groups are equally represented in the Hungarian, Japanese, and Yugoslav institutions, whereas in the other laws in this group the representation of employers and workers is unequal. In some countries (Austria, France for miners' insurance, Germany, Greece, Lithuania, Luxemburg, Poland) employers have one-third of the votes and the insured two-thirds. The Czechoslovak law establishes a certain balance between employers' and workers' representation. The employers have one-fifth of the votes on the managing committee and four-fifths on the audit committee, the workers conversely having four-fifths on the managing committee and one-fifth on the audit committee. A similar provision applies to miners' insurance in Czechoslovakia.

Group (4). — Certain laws provide that the administrative bodies must include, in addition to representatives of employers and insured, persons designated by the public authorities. This is so in Chile, where the local funds set up by the Act are administered by an administrative council of nine, of whom three are elected by employers, three by the insured, while three are appointed by the President of the Republic. Similarly, in the new provinces of Italy, three of the nine members of the administrative council of the territorial funds must be chosen from among social insurance experts and appointed by a Decree of the Minister of National Economy. In Norway managing committees of district funds are appointed by the communal authorities and are each composed of nine persons of whom five are insured persons, two are employers, and two unspecified. In the Roumanian law (former Kingdom and Bessarabia) the Central Office for Crafts, Credit and Workers' Insurance, which is responsible for organising and administering

the Sickness Insurance Fund, is managed by an administrative council of thirteen persons appointed by Royal Decree, two of whom are chosen from among employers, two from among artisans and workers, and the remaining seven are designated by the Finance Minister or the Minister of Labour, Co-operation and Social Insurance. In the Swiss Cantons in which insurance is compulsory the public funds are administered by committees, on which the cantonal or communal authorities are represented as well as the insured. Similarly, the authorities appoint representatives to the administrative bodies of the insurance institutions set up under the special seamen's insurance systems of Belgium and France.

§ 3. — Machinery and its Functions

If by the law the management of insurance is reserved to the State, it entrusts the administration to a Ministry or public department set up for the purpose, together with its agents. If, on the contrary, provision is made for independent insurers, in whose work the parties directly concerned participate, they must have machinery representing them and acting on their behalf.

An insurance institution will have machinery for deliberation, execution, and supervision, though this is not always the rule. In many countries supervision is solely in the hands of the public authorities, and the law does not provide for independent supervisory machinery (Germany, Great Britain, Irish Free State, Japan). In other countries the institution has only one authority which is at once deliberative and executive (Chile, France for miners' and seamen's insurance, Greece). Finally, under certain laws a special authority is set up side by side with the three bodies referred to above, for determining certain types of disputes. These will be discussed in Part V concerning jurisdiction and sanctions (Austria, Lithuania, Poland).

The deliberative body is usually called the "general meeting" or "delegate meeting" (*assemblée générale, assemblée de délégués, Hauptversammlung, Ausschuss*) the executive body, the managing committee (*comité directeur, Vorstand*), and the independent supervisory body, the audit committee, supervisory committee, or control committee (*commission de vérification des comptes, commission de surveillance, commission de contrôle, commission de revision*).

The general meeting has competence in particular to approve the annual report and balance sheet, elect the other bodies, amend the rules and settle questions raised by the management, as also to make arrangements with other funds, the medical profession, etc. The managing committee is chiefly responsible for the administration and representation of the fund, the preparation of the annual report and the engagement of staff. The independent supervisory body audits the accounts and the annual financial report of the committee.

From the point of view of the delimitation of the functions of the different administrative bodies, it is interesting to observe that whereas in Germany all questions not within the competence of the committee are settled by the delegate meeting, in countries such as Austria, Czechoslovakia, Hungary and the Serb-Croat-Slovene Kingdom the committee is competent for all questions except those which under the law are within the competence of the general meeting.

Apart from certain exceptions (Czechoslovakia and Norway) the composition of all the administrative bodies of the institutions is in principle the same.

The general meeting may consist either of the whole body of the insured persons and employers acting in their own behalf, or, in the case of very large funds, of delegates elected by the insured and the employers concerned. Most laws recognised only delegate meetings. This applies to the German law, which fixes the maximum membership of the meetings of the territorial institutions at 90 and of the works funds at 50. In Hungary, too, the law recognises only delegate meetings for the district funds. This is also the case in Japanese law, where the meeting must have not less than 12 members; in Lithuanian law, where the meeting must have not more than 45 members; in Polish law, with a maximum membership of 90; and in Czechoslovak law (general system), with a minimum membership of 30 and a maximum of 150, while in miners' insurance the minimum is also 30. Representatives of employers and insured are usually elected separately in their respective groups, the employers' voting power being determined by the number of compulsorily insured persons employed in his undertaking.

In other laws, on the contrary, the meeting comprises the whole membership of the fund, and delegate meetings are prescribed only if this membership exceeds a certain figure. Thus in Austria, if a fund has less than 300 members the meeting consists of the whole membership. A similar provision is to be found in Esthonian and

Latvian law. In Norway the meeting of a district consists in principle of the whole membership, but the rules may provide for the substitution of a meeting of elected delegates. The particular feature of the Russian system is that the general meeting of the territorial and trade insurance institutions consists of the local trade union conference, whose composition and method of election are defined by the local inter-trade union authority.

The committee in countries where employers and workers are represented in the meeting is elected by the representatives of the two groups in the general meeting. In Norway, however, the worker and employer members of the committee are designated by the communal authorities. The number of members of the committee is fixed either by the rules of the fund (Austria, Esthonia, Germany, Great Britain, Hungary, Japan, Latvia) or by the law. The number may be fixed definitely (Czechoslovakia: 10; Norway: 9 members), or a minimum number of representatives may be laid down (France, miners' insurance: 9), or a maximum number (Yugoslav Central Institution: 36), or finally both a maximum and a minimum may be fixed, leaving the rules, a certain latitude (Lithuania: 6 to 9; Poland: 9 to 18, Russia: 3 to 7).

The chairman of the general meeting and of the managing committee of territorial funds and mutual benefit societies is usually appointed freely by the delegates, although in certain institutions such as the Hungarian National Fund, or the Yugoslav Central Workers' Insurance Institution, he must be alternately an employer and a worker. For trade funds certain laws provide for the chairmanship of an employers' representative (Germany). Others empower the fund to grant employers this privilege under the rules (Austria, Hungary). If the management of insurance is reserved to the workers, the latter elect their chairman from among themselves (Esthonia, Latvia). Finally, if the chairman is a workers' representative, the law may provide that the vice-chairman shall be an employers' delegate (Czechoslovakia, miners' insurance).

The supervisory committee is appointed by the delegate meeting, except in Norway and the new provinces of Italy. Employers and workers vote separately. The number of members of the committee may be determined by the rules (Austria, Esthonia, Hungary, Latvia, Norway) or by the Act (Czechoslovakia, general system: 10, miners' insurance: 5; Lithuania: 6; Poland: 6; Russia: not less than 3). Membership of the administrative bodies is honorary, but some laws provide that the members of the managing committee may in certain conditions obtain compensation for the loss of time involved

in their participation in the work of the institution. In Russia, persons working whole time as committeemen are remunerated.

§ 4. — Provisions of National Legislation on the Formation and Machinery of Institutions

The provisions of the different national laws concerning the formation, recognition, and machinery of sickness insurance institutions are analysed below. Wherever the necessary data are available, particulars are given of the cost of administration of the institutions,

AUSTRIA

The initiative in creating insurance institutions may be taken either by the authorities (district funds), or by the employer (works funds), or guild (guild funds), or finally by those concerned (mutual benefit societies).

The district funds are set up by the provincial political authorities in each judicial district at the seat of the district court (section 12 of the Order of the Federal Government of 20 November 1922 respecting the text of the Act on workers' sickness insurance). If special circumstances so require, the political authorities of the Province may order that a single sickness fund shall be instituted for several judicial districts, or that several sickness funds shall be instituted in one judicial district.

The rules of these funds are drawn up by the provincial political authorities, after consulting representatives of the employers and insured persons, on the lines of a set of model rules published by order. These rules and any subsequent amendments must be approved by the provincial governor (section 14, subsection 1). If when a new district fund is set up it is proposed that the rules shall provide for benefits exceeding the statutory minimum, the industrial inspector, the chamber of commerce and industry, and the council of wage-earning and salaried employees must be consulted (section 14, subsection 2).

Works funds are created solely on the initiative of employers, subject however to the following conditions:

- (1) The employer must employ not less than 100 persons liable to insurance in one undertaking or in several neighbouring undertakings (section 42, subsection 1); although in certain cases the right to set up a fund may be granted even if the number of workers employed is less than 100 (section 42, subsection 3).
- (2) The fund must not endanger the effective working of the district sickness fund (section 42, subsection 2).

If employment in the undertaking involves particular risk of sickness, the provincial political authorities may compel the employer to set up a works fund (section 43). Similarly, they may order building employers to institute works funds for the workers employed on temporary constructional undertakings, provided that a considerable number are employed for a considerable period (section 54).

The right to engage in statutory insurance may also be granted to certain other types of funds in existence when the 1922 Act came into force. Thus guild funds, mutual benefit societies, railway benefit societies, benefit societies in connection with steamship undertakings engaged in public transport, and those in connection with undertakings administered by the Federal Government may be accepted as insurers on the following conditions:

- (1) The benefit granted under the rules must be in accordance with the legal minimum rate for sickness insurance (sections 6-8) ¹

¹ This condition also applies to miners' mutual benefit societies (section 59, subsection 2).

- (2) The employers' (or State) contributions must not be less than those they would have to pay under the Act (this condition does not apply to mutual benefit societies)
- (3) They must offer their members the same advantages as those specified by the Act in case of unemployment (section 13, subsection 3), with respect to entrance fees (section 13, subsection 5), the claim to benefit, and penalties for malingering (section 35). Further, disputes between insured persons and the funds must be referred for settlement to the supervisory authorities or the arbitration court (section 41).¹

The present tendency in Austria is to reduce the number of institutions, and no new fund has been formed since 1917. The right to set up sickness funds was suspended until further notice by the Act of 20 November 1917 (section VIII) and this prohibition, which applies to all types of funds is still in force.

Any territorial fund is entitled to acquire rights and incur liabilities in its own name and to sue and be used in the courts. Liability for its obligations extends only to its assets (section 15).

The administrative bodies of the funds are the general meeting, the managing committee, the supervisory committee, and the arbitration court.

General Meeting

The general meeting consists either of the members of the fund acting in their own right or (if the fund has a membership of over 300) of delegates elected by the members from amongst their number (section 17).

Employers who employ compulsorily insured members of a district fund have the right to be represented on the general meeting and other administrative bodies of the fund. This representation is determined by the rules, account being taken of the proportion between the contributions of insured and employers. In no case may the employers have more than one-third of the votes in the general meeting or the other administrative bodies (section 18). The rules of works funds may provide that the chair at meetings of the managing committee and general meeting shall be taken by the employer or his representative (section 17).

The following functions are reserved for the general meeting:

- (1) The election of the managing committee and supervisory committee.
- (2) The examination of the annual report of the managing committee and the discharge of the latter from its responsibilities.
- (3) The conduct of actions brought by the fund against members of the managing committee.
- (4) The amendment of the rules of the fund (section 17).

Managing Committee

The managing committee is elected from among the members of the fund by the insured and employers voting separately. In guild funds the representatives of the insured are elected by the meeting of journeymen and mates, and the representatives of employers by the meeting of members of the guild.

The managing committee is responsible for all the administration and representation of the fund except in the matters expressly reserved by the rules for the decision of the general meeting. In particular it is responsible for the proper application of effective measures for supervising sick persons (section 16).

Supervisory Committee

This committee is elected in the same way as the managing committee. The rules of every district or works fund must provide for its constitution, competence and term of office (section 14, subsection 3, and section 47).

¹ The conditions with reference to penalties for malingering and to disputes do not affect mutual benefit societies. Those with respect to disputes do not apply to the funds connected with undertakings run by the Federal Government.

Arbitration Court

In each fund an arbitration court must be set up with sole powers to settle all disputes concerning claims to benefit between insured persons and the fund (section 41, subsection 2).

COST OF ADMINISTRATION

The following table shows the proportion of contributions used to meet the cost of administration from 1920 to 1925.

ADMINISTRATIVE EXPENSES PER CENT OF CONTRIBUTIONS BY TYPE OF FUND

Year	District funds	Works funds	Guild funds	Mutual benefit funds
1920	14.7	0.2	14.9	14.1
1921	13.9	0.3	13.5	13.6
1922	17.5	0.4	17.4	16.5
1923	11.3	0.4	9.5	9.6
1924	10.9	0.4	9.5	10.8
1925	13.2	0.4	11.8	13.2

The table shows that the cost of administration fell for all the types of fund during the period in question except the works funds. It was roughly the same for the district, guild, and mutual benefit funds. The very small proportion of contributions of works funds spent on administration is due to the fact that the administrative expenses of these funds are very largely met by the employer.

For the mining funds, the ratio of administrative to total expenditure was as follows during the period 1919-1924.

ADMINISTRATIVE EXPENSES OF MINING FUNDS PER CENT. OF ANNUAL EXPENDITURE

Year	Per cent.
1919	6.8
1920	7.7
1921	10.6
1922	11.4
1923	7.2
1924	5.5

BELGIUM

SEAMEN'S INSURANCE

Seamen's insurance is in the hands of one institution, the Relief and Provident Fund for Seamen Sailing under the Belgian Flag, at Antwerp. It is managed by a committee of ten members, two of whom are permanent and the remainder appointed for four years (Article 3 of the rules of 28 February 1885). The offices of president and treasurer are permanent and held by the Antwerp Collector of Shipping Dues.

The president as well as the other members are appointed by the Crown, being chosen from among officials in the Department of Naval Administration, shipowners, captains in overseas trade, shipbrokers, and the principal traders in the Belgian ports (Article 5). The committee draws up its own regulations (Article 8); it meets once a month (Article 7); and, in addition to its special functions under the rules, it has the right to give its opinion on all matters connection with the administration of the Fund referred to it by the Minister (Article 9).

The cost of administration is low. It was 4,711 86 francs or 1 franc per insured person, in 1924 in respect of all risks (sickness, invalidity, old age, death, shipwreck).

BULGARIA

Sickness and maternity insurance, like insurance against other risks, is managed by public institutions. For this purpose special central and local bodies were set up to administer the law on social insurance.

Central Authorities

The central administration of social insurance is in the hands of the Ministry of Commerce, Industry and Labour (Labour Department) to which a special Insurance Office is attached (section 190, subsection 1 of the Administrative Regulations of 25 June 1924). This special Office is divided into three sections: (a) administrative section; (b) health section; (c) accounts section. The first is managed by the head of the special insurance office and is competent for the whole administration of insurance. The second is managed by the senior medical inspector, and the third by the chief accountant (section 190, subsection 2 of the Regulations).

If the service is extended, the Minister of Commerce, Industry and Labour may set up a special labour and social insurance section with the necessary divisions and offices (section 46, subsection 1 of the Act and section 190, subsection 3 of the Regulations).

The head of the Labour Department is responsible for the general management and supervision of the work of the Insurance Office (section 192 of the Regulations). A certain number of medical inspectors are attached to the Insurance Office for the purpose of checking the accounts submitted by the doctors in charge of sick persons and their general work (section 193, subsection 1 of the Regulations). Similarly a certain number of insurance inspectors are attached to the Insurance Office whose duty it is to watch over the proper administration of the Act and Regulations (section 193, subsection 2 of the Regulations).

At the end of each financial year the Insurance Office must draw up an annual report on the growth of the Fund, the number of insured, the number of persons being treated, the method of treatment, the sicknesses from which workers have recovered, the persons who have recovered, the persons who are permanently disabled as a result of a sickness or accident, the increase or reduction of pensions, and in general on all points which during the year have necessitated action by the Insurance Fund (section 194, subsection 1 of the Regulations).

The expenses for the staff and supplies for the insurance service are met by the Social Insurance Fund (section 46, subsection 3).

Local Authorities

The local administration of insurance is entrusted to the local labour inspectors, who if necessary may be given assistants at the rate of one assistant for every 3,000 to 5,000 persons insured (section 195, subsection 1 of the Regulations).

The local labour inspector is responsible for the general supervision of the work of his assistants, and must personally supervise the administration of the Act and Regulations by the undertakings. For the purpose, he must visit the undertakings in his area at least twice a year (section 195, subsection 2 of the Regulations).

The labour inspectors must make quarterly reports of their work and that of their assistants, as well as an annual report, to be completed not later than February each year (section 195, subsection 3 of the Regulations).

The inspector's assistants are responsible for supervision in the districts placed under them.

- (a) They must inspect all the undertakings as often as possible. Four times a year they must make a general local inspection and record the results in a special register for the purpose.

- (b) They must supervise the curative treatment of the sick and try to prevent abuses
- (c) They must carry out the instructions of the local labour inspector and their superior officers.
- (d) They must submit a quarterly report of their work to the local labour inspector (section 196 of the Regulations).

The labour inspection secretary-treasurers act as accountants for the insurance service and must pay a deposit on taking up this duty (section 197 of the Regulations)

Applications for medical attendance and cash benefit are decided on by the labour inspection authorities under the supervision of the central administrative authorities. Any disputes are settled by an arbitration court, consisting of one of the local justices of the peace as chairman and one representative each of employers and workers (section 47, subsection 2)

CHILE

The Central Fund and the local funds in the chief towns of the departments are set up by the public authorities (section 6 of the final text of the Sickness and Invalidity Insurance Act contained in Decree No. 34 of 22 January 1926). For the present the Santiago Savings Bank for the Department of Santiago and the National Savings Bank for other departments have been made responsible for the territorial institutions (transitional provisions of the Act).

A trade or mutual benefit fund which wishes to act as a statutory insurer must include provisions in its rules requiring it to provide the medical benefits and drugs specified in the Act, and obtain the authorisation of the President of the Republic, which is granted after consultation with the Central Fund (section 2)

The administration of the local funds is in the hands of an administrative committee of nine persons, of whom three must be elected by the meeting of the insured, three by the meeting of the employers liable to pay insurance contributions, while three are appointed by the President of the Republic. Among the persons appointed by the President of the Republic one must be a doctor chosen from members of the profession outside the fund, provided of course that there are a sufficient number of doctors in the district (section 7).

CZECHOSLOVAKIA

GENERAL INSURANCE SYSTEM

The Act of 9 October 1924 entrusts to the Central Social Insurance Institution, the highest supervisory authority, the work of setting up district sickness funds. A district fund is as a rule established at every place which is the seat of a political authority of first instance, but in particular circumstances the Central Institution may fix the areas and headquarters of district funds in some other way (section 24, subsection 4)

Under Czechoslovak law, new trade funds may not be created. The Act accepts as statutory insurers only certain funds of this type in existence when it came into operation. Thus only the works funds in existence on 1 January 1924 may continue their operations (section 26).

Guild funds may continue their operations if on 1 January 1924 they had at least 4,000 members employed by compulsory members of the guild (section 27, subsection 1).

Similarly, the Act does not authorise the formation of new mutual benefit societies. Only those association sickness funds which were set up under the Associations Act of 26 November 1852, and had on 1 January 1924 at least 4,000 members liable to insurance may be recognised as statutory insurers (section 28). A similar provision applies to registered friendly societies established under the Act of 16 January 1892 to which a certificate was issued before 1 July 1919 under section 7 of that Act (section 29, subsection 1). Further,

certain mutual benefit societies for salaried employees may act as statutory insurers if before 1 January 1924 they insured only persons subject to the Employees' Pensions Insurance Act and at that date had at least 2,000 members (section 29, subsection 2)

Sickness insurance institutions have legal personality. They have power in their own name to acquire rights and contract liabilities and to sue and be sued in the courts (section 23, subsection 2). They are administered by a general delegate meeting, a management committee, a supervisory committee, and a manager (or director) (section 31)

General Delegate Meeting

The general meeting consists of delegates elected for a term of four years by the insured persons entitled to vote. The number of delegates is fixed by the rules and must not be less than 30 nor more than 150 (section 32, subsections 1 to 3).

The general meeting of delegates is competent:

- (1) To elect from among the insured persons eight members of the managing committee, two members of the supervisory committee, the members of the arbitration court, and their substitutes.
- (2) To decide on the annual report of the managing committee and discharge the latter from its responsibility on the basis of the report of the supervisory committee.
- (3) To decide on the prosecution of claims against members of the managing committee or of the supervisory committee arising out of their official conduct.
- (4) To decide on the amendment of the rules.
- (5) To decide on all recommendations of the managing committee respecting matters outside the scope of the ordinary operations, and especially respecting the acquisition or alienation of real property or of the contracting of liabilities upon it (section 56).

The meeting is convened at least once a year by the managing committee, which must convene it within a month if at least one-fifth of the delegates so demand and give their reasons. The decisions of the meeting are taken by a simple majority of the persons present, but a two-thirds majority is required for a decision on an amendment of the rules (sections 57 and 58).

Managing Committee

The managing committee consists of ten members, eight of whom are elected by the general meeting from among the insured persons, and two by the employers (section 59, subsection 1). The term of office of the managing committee is four years (section 61, subsection 1).

The committee elects a president and vice-president from among its own members. On the request of a minority of not less than three members, the vice-president must be elected from that minority (section 62).

The committee manages the sickness insurance institution and represents it in all matters not reserved by law or the rules for decision by the general meeting or any other administrative body of the institution. In particular it is competent to make contracts with medical practitioners, midwives, dispensing chemists, and hospitals, and to engage and dismiss officials and salaried employees of the institution (except the officials appointed by the Central Social Insurance Institution) (section 63)

Supervisory Committee

The supervisory committee consists of ten members, of whom two are elected by the general delegate meeting and eight by the employers whose employees are insured with the institution (section 64, subsections 1 and 2).

The members of the supervisory committee may attend the sessions of the managing committee in an advisory capacity, and vice versa (section 67).

It is the duty of the committee to supervise the observance of the Act, rules and other regulations and the general management of the insurance

institution. For this purpose it checks the accounts and balance sheet and makes a report to the general meeting (section 66, subsection 1)

Managers

For every local sickness insurance institution with not more than 2,000 members liable to insurance on an average for the last three years, the Central Social Insurance Institution appoints a manager, who also undertakes the duties of treasurer and accountant. If the institution has from 2,000 to 5,000 members, the Central Institution appoints a second official for the duties of treasurer and accountant. Finally, for institutions with a membership of over 5,000, it appoints a manager, treasurer, and accountant (section 69, subsection 1). The officials of sickness insurance institutions must be Czechoslovak citizens (section 68, subsection 1). They are under the disciplinary authority of the Central Insurance Institution and not of the general meeting or managing committee of the local institution.

The manager is the principal official of the sickness insurance institution. He directs its operations, makes recommendations to the managing committee concerning the organisation, the engagement, and dismissal of officials, and all other necessary action. He attends the general meetings and sessions of the managing committee and supervisory committee in an advisory capacity (section 70).

The Central Social Insurance Institution draws up model service and disciplinary rules for these groups of officials, after consulting the organisations of officials of sickness insurance institutions and federations of such institutions. These rules must be approved by the Ministers of Social Welfare and Finance (section 69, subsection 4).

MINERS' INSURANCE

Under the Act of 11 July 1922, which set up a special compulsory system of insurance for miners, a district benefit society must as a rule be established for the area of each district mining authority or for the neighbouring areas of several such authorities. These funds are established automatically by the law, their number, areas, and seats being fixed by order. Further, in agreement with them the Ministry of Public Works may alter, subdivide, or amalgamate their areas and transfer their seats in view of special conditions in the different districts (section 27, subsection 2).

In the capacity of sickness funds, the district benefit societies independently administer insurance against sickness (section 28, subsection 4). They have power in their own name to acquire rights and contract liabilities and sue or be sued (section 29, subsection 1).

Their administrative bodies are the general meeting, the managing committee, and the supervisory committee.

General Meeting

This consists of delegates of the members and representatives of the employers. The number of members' delegates must not be more than 30 and the number of employers' representatives is half that of the members' delegates. Their term of office is three years (section 32, subsection 1).

The general meeting is alone competent for the election of the other administrative bodies of the fund and the assessors on the arbitration court, for decisions concerning the rules and amendments thereof, for decisions concerning the annual report of the managing committee and those concerning the prosecution of claims against members of the other administrative bodies (section 43).

Managing Committee

This committee is elected by the general meeting, the members and employers voting in separate groups. It consists of eight members and eight substitutes chosen by the members' group and two members and two substitutes chosen by the employers' group. Its term of office, too, is three years. The president is elected from among the members of the committee by a simple majority. On the request of a minority of not less than two members a vice-president must be elected from that minority (sections 38 to 40).

The managing committee is responsible for everything connected with the administration and representation of the fund, except in matters which are expressly reserved for decision by the general meeting or by a joint meeting of the managing committee and the supervisory committee (section 41).

Supervisory Committee

This committee consists of five members (4 employers and 1 worker) elected by the general meeting, the two groups voting separately. It is its duty to supervise the general activities of the administrative bodies of the fund and in particular the strict observance of the Act, rules, and other regulations, to examine the accounts, check the balance sheet, and report to the general meeting (sections 44 and 45).

Questions concerning expenditure exceeding that permitted under the law and the rules, as also those concerning collective agreements with medical practitioners, are reserved for decision by a joint session of the managing committee and the supervisory committee (section 46).

ESTHONIA AND LATVIA

In these two countries the regulations concerning the formation of the works funds, which are the only form of fund allowed by the law, are the same. The initiative is taken by the persons liable to insurance, authorisation is granted by the labour inspector after examination of the draft rules, and if the latter do not conform to the standard rules it is granted by the higher administrative authorities.

The regulations concerning the creation of institutions vary according to the size of the undertaking, i.e. they differ for undertakings employing 500 or more workers and those employing less.

In large undertakings the workers may choose between setting up a special works fund, setting up a fund in common with the workers employed in one or more other undertakings, and affiliating to a joint fund already in existence (section 274 of the Esthonian Industrial Code and sections 13 to 15 of the Latvian Sickness Insurance Code of 1922 promulgated by the Ministry of Justice). Workers in undertakings employing less than 500 workers, on the contrary, are not entitled to set up a special works' fund unless they obtain special authority from the labour insurance authorities in Esthonia (section 275 of the Industrial Code) or of the Ministry of Social Welfare in Latvia (section 15 of the Act).

When a fund applies for registration, the procedure adopted is to send a notification of its constitution to the labour inspector, who orders its registration if the draft rules accompanying the notification are in conformity with the standard rules, or else he submits the notification for approval to the labour insurance authorities in Esthonia, or the Ministry of Social Welfare in Latvia if the draft rules do not conform. The fund is considered to have been lawfully constituted if within a fortnight of receipt of notification the applicants have not been informed of the reference of the matter to the higher authority, which in the event of refusal must notify the reasons within one month (sections 285 and 286 of the Industrial Code and sections 24 and 25 of the Latvian Act).

The sickness funds as such have the power to acquire rights and assume obligations; in particular they may acquire property and other rights with respect to real property, and they may also enter into contracts and sue and be sued (section 282 of the Industrial Code and section 21 of the Latvian Act).

Their administrative bodies are the general meeting, the managing committee, and the audit committee.

General Meeting

The general meeting consists of representatives of members of the fund. If the membership of the fund is less than 300 the meeting may consist of all the members (section 342 of the Industrial Code and section 80 of the Latvian Act). The number of delegates is fixed by the rules: they are chosen by the members of the fund from among their own number. The method of election

and the term of office of the delegates are fixed by the rules. Each delegate has one vote in the general meeting and cannot transfer his vote to another person (section 343 of the Industrial Code and section 81 of the Latvian Act).

Half the membership of the general meeting constitutes a quorum. If the number of delegates present falls below this figure, a second meeting is convened within a fortnight which has power to decide whatever the number of delegates present (section 347 of the Industrial Code and section 84 of the Latvian Act).

The functions of the general are.

- (1) To elect the members of the managing committee.
- (2) To order audits of the fund and take the necessary measures for the purpose.
- (3) To examine, revise, and approve the annual report of the managing committee.
- (4) To elect the audit committee.
- (5) To examine complaints by members of the fund and owners of undertakings of actions of the managing committee.
- (6) To settle the questions raised by the management of the fund and the members of the general meeting.
- (7) To decide on questions relating to the responsibility of members of the managing committee for irregular actions, and on the dismissal of members of the committee.
- (8) To decide on the amendment of the rules.
- (9) To decide on the dissolution of the fund (section 350 of the Industrial Code and section 86 of the Latvian Act).

Within a period prescribed by the rules of the fund, the members of the fund and the owners of undertakings may appeal against the decisions of the general meeting to the labour insurance authorities in Esthonia and the Ministry of Social Welfare in Latvia, which authorities cancel any decisions contrary to the law or the rules (section 352 of the Industrial Code and section 88 of the Latvian Act).

Managing Committee

The managing committee is elected by secret ballot by the general meeting from among its members (section 353 of the Industrial Code and section 89 of the Latvian Act).

The committee is responsible for managing the business of the fund and in particular for determining the wages of its members with a view to calculating their contributions. It checks the cases of sickness and their duration and it determines what cash benefit is due. The committee also draws up the annual report on the work of the fund (section 357 of the Industrial Code and section 93 of the Latvian Act).

An appeal against the decisions of the managing committee may be taken to the general meeting of the fund (section 358 of the Industrial Code and section 94 of the Latvian Act).

Audit Committee

The audit committee, which is elected from among the members of the general meeting, is responsible for checking the accounts and the annual financial report of the managing committee, examining the annual report, and submitting its report to the general meeting for approval.

The owner of the undertaking may attend the meetings of this committee in his capacity of member or send a delegate to represent him. In the case of joint sickness funds, the employers in the affiliated undertakings are entitled to elect their representatives on the audit committee by mutual agreement. If there are valid reasons the managing committee may reject the representative of the employer or employers on the audit committee. Disputes concerning the validity of the reasons for rejection are settled by the Labour Insurance Authority in Esthonia and the Ministry of Social Welfare in Latvia.

The members of the audit committee may attend the meetings of the managing committee and the general meeting in an advisory capacity (section 353 of the Industrial Code and section 87 of the Latvian Act).

FRANCE

Alsace-Lorraine

The method of setting up the insurance institutions and the composition, method of election and functions of the administrative bodies of the sickness funds in Alsace-Lorraine are the same as in Germany (see page 621).

The administrative expenditure of the funds from 1919 to 1923 is shown in the table below

ADMINISTRATIVE EXPENSES, AVERAGE COST PER INSURED, AND PERCENTAGE OF TOTAL EXPENDITURE OF THE FUNDS

Year	Expenditure on staff	Other general expenses	Total administrative expenses		
			Amount	Per insured	Per cent of total expenditure
	Frs.	Frs	Frs	Frs	
1919	1,344,580	352,173	1,696,743	4.96	5.88
1920	2,097,378	612,530	2,709,908	7.03	7.22
1921	2,480,489	654,073	3,134,562	8.01	5.56
1922	2,554,182	646,843	3,195,025	7.73	4.81
1923	2,883,947	692,300	3,506,247	7.99	4.86

The average cost per insured during the same period is shown for the different types of funds in the table below, the railway fund and post office funds being shown separately. The low figures for the works' funds is due to the fact that in these the expenses are largely borne by the employers.

ADMINISTRATIVE EXPENSES PER INSURED BY TYPE OF FUND

Year	Local funds	Works funds	Guild funds	Railway fund	Post office funds	Approved mutual benefit funds
	Frs.	Frs	Frs.	Frs.	Frs	Frs.
1919	8.69	0.38	9.74	—	—	—
1920	12.55	0.89	14.91	0.57	0.38	—
1921	13.73	1.38	18.20	0.29	0.22	28.02
1922	13.18	1.14	19.14	0.24	0.99	24.87
1923	13.12	1.23	20.33	0.64	1.64	26.40

Miners' Insurance

Miners' insurance is administered by the mutual benefit societies. The area for which such a society is set up is defined so as to include the workers and employers in a single concession, though it may be confined to the workers in particular branches of the industry. After a direct agreement between those concerned is reached, the administrative authorities merely register the delimitation of the area. Otherwise it is defined by a Decree of the Council of State (Art of 1894, section 9). In any case the area is implicitly determined by the Decree convening electors. It is the duty of the first administrative council to draw up the rules, which are submitted through the medium of the Prefect to the Minister of Labour for approval, after which they are notified to the employer.

Each mining benefit fund is administered by an administrative council of not less than nine members, one-third of whom are appointed by the employer

and the remaining two-thirds are elected by the wage-earning and salaried employees from among the participating members. In addition there are three substitute members who take the place of the ordinary members in the event of their absence. The employer may decline to make use of his power to appoint one-third of the members of the council, in which case these members are elected by the workers (section 10).

The members of the council are elected for three years on the *scrutin de liste* system, one-third being renewed annually. All persons employed underground or on the surface who are of French nationality are entitled to vote if they have civil rights and are included in the last payroll. Electors of 25 years of age who have been employed for more than five years in the undertaking to which the benefit fund is attached are eligible for membership. During the first five years of working, however, the period of service required is reduced to that in which the undertaking has been in existence (section 11).

The administrative council appoints from among its members a president, secretary, and treasurer.

It determines the deduction to be made from the wages of each person employed (section 6). It decides what proportion of the available annual surplus is to be placed in the Government Deposit Fund (*Caisse des dépôts et consignations*) and what is to be retained by the benefit fund (section 16). Its other functions, in particular those relating to the determination and granting of benefit, are defined by the rules of each fund.

The data available for the post-war years do not distinguish the general expenses. For 1913 the statistics for the mining industry give the following information

GENERAL EXPENSES OF MINING BENEFIT FUNDS IN 1913

	Expenditure		
	Amount	Per member	Per cent. of total expenditure
Administrative and legal expenses	Frs 171,962	Frs 0.71	1.69
Attendance cards, fees of visitors of the sick, miscellaneous	91,880	0.38	0.90
Total	263,842	1.09	2.59

Seamen's Insurance

Seamen's insurance is administered by the French Seamen's Provident Fund. The only administrative body of this fund is the administrative council, which consists of:

- (1) Two senators and two deputies, appointed by the Minister of Marine, one of whom is president.
- (2) Two representatives of the Superior Council of the Disablement Fund, appointed by that Council.
- (3) A councillor of State and a councillor of the Court of Accounts, appointed by the Minister of Marine.
- (4) A director of the mercantile marine and the manager of the Disablement Fund, who are *ex-officio* members.
- (5) Five representatives of shipowners and five representatives of members of the fund, appointed by their representative committees or associations as follows: one captain in oversea trade, one representative of engine-room officers, one representative of deck and engine-room hands, one representative of the general service, and one fisherman.

The members specified under heads (1), (2), (3), and (5) are appointed for three years.

The administrative council is consulted in particular on the use and investment of the moneys of the Provident Fund, and gives its advice on questions and proposals concerning the organisation and regulation of the institution (Act of 1905, section 18).

The Minister of Marine is responsible for the management of the Provident Fund with the assistance of the officials and agents who administer and manage the Seamen's Disablement Fund (section 17).

The accounts of the Provident Fund are prepared annually and are not classified (Ministerial Instructions of 20 April 1906, section 188). The accounts of the Provident Fund are kept by the treasurer of the Disablement Fund.

GERMANY

GENERAL SYSTEM

The initiative in setting up the sickness insurance institutions and drafting the rules is taken by the federation of communes (local funds, rural funds), or the employer acting in agreement with the works council (works funds), or the guild (guild funds), or finally the insured persons alone (approved mutual benefit funds).

The general local funds and rural funds are as a rule established for the district of a local insurance office by decision of the federation of communes. If the fund is not established in due time the Superior Insurance Office orders its establishment, but an appeal against such a decision may be taken to the supreme administrative authority. If the final order is not carried out within the prescribed time limit, the Superior Insurance Office itself organises the fund or requires the local insurance office to do so (sections 226 and 231-233 of the Federal Insurance Code).

Whereas the creation of general local sickness funds is compulsory for the whole of Germany, that of the rural funds depends on the law of the particular federal State (section 227). A rural sickness fund must have at least 1,000 compulsorily insured members if it is to be set up in addition to the general local fund (section 228). In cases where the general local fund would not have at least 1,000 compulsory members, its establishment in addition to the rural fund may be omitted (section 230).

Works funds can only be established for undertakings employing ordinarily at least 150 compulsorily insured persons and for agricultural or inland navigation undertakings employing ordinarily at least 50 compulsorily insured persons.

A trade fund may be set up either on the initiative of the employer (works funds) or of the guild (guild funds). In the case of a works fund the consent of the works council is necessary (section 245). In that of the guild fund, the journeymen's committee, the communal authority of the place where the guild has its headquarters, the chamber of handicrafts, and the supervisory authority of the guild must be consulted (section 251, subsection 2).

The only case in which a person may be compelled to set up a works fund on the order of the Superior Insurance Office is that of building owners temporarily employing a large number of workers (*eine grössere Zahl von Arbeitern*) (section 249, subsection 1).

A works or guild fund may not be set up unless:

- (1) It does not imperil the existence or solvency of existing general local funds and rural funds
- (2) Its benefits under the rules are at least equivalent to those of the competent local fund.
- (3) Its solvency is permanently ensured (sections 248 and 251).

The prescribed procedure for setting up a fund is to send an application for approval to the local insurance office, which submits it for opinion to the rural and local funds concerned, and then transmits it with these opinions to the Superior Insurance Office, which is alone competent to allow or refuse the creation of a trade fund (sections 252 and 253).

Insurance institutions may sue and be sued (section 4). In the opinion of all commentators on the German law these institutions must be considered to be

public corporations and not administrative bodies (*öffentlich-rechtliche Körperschaften ohne Behördeneigenschaft*).

The sickness funds are administered by the delegate meeting (*Ausschuss*) and managing committee (*Vorstand*) (section 327).

Delegate Meeting

In the territorial funds and guild funds this meeting consists as to one-third of representatives of the employers concerned, and as to two-thirds of representatives of the insured persons, subject to a maximum of 90 representatives in all (sections 332 and 341). In the guild funds the two groups may elect an equal number of representatives, provided that they contribute equally to the funds (section 341). The delegate meeting of works funds consists of the employer or his representative, and representatives of the insured persons, up to a maximum of 50. The employer has half the number of votes granted by the rules to the insured persons (section 338).

In the local funds and guild funds the adult employers and workers belonging to the fund choose their representatives from among their respective groups. The elections are conducted separately by the managing committee. The number of votes to which individual employers are entitled depends on the number of persons liable to insurance they employ. By the rules this right may be limited and a maximum number fixed, in which case the approval of the Superior Insurance Office is necessary (sections 333 and 341). In the works funds it is the adult insured persons who choose from among themselves their representatives for the delegate meeting under the direction of the managing committee (section 339).

The delegate meeting decides on all matters not referred by the Act, the rules of the fund, or the service rules to the managing committee, but the Act expressly reserves the following matters to the meeting.

- (1) The drawing-up of the estimates
- (2) The adoption of the annual accounts
- (3) The representation of the fund in relation to the members of the managing committee
- (4) The conclusion of agreements and contracts with other funds
- (5) The establishment of local and pay offices.
- (6) The amendment of the rules
- (7) The winding-up of the fund or its voluntary amalgamation with other funds

The decisions taken under heads (6) and (7) need a majority of the votes of employers and insured persons separately (section 345).

The consent of the delegate meeting is necessary for

- (1) The service rules for salaried employees, which are drawn up or amended by the managing committee
- (2) Resolutions of the managing committee concerning the establishment of hospitals and convalescent homes (section 346).

The delegate meeting also decides, by special regulation, which must be approved by the Insurance Office, the manner in which sick persons are to be notified and supervised and the disciplinary measures they must observe (section 347).

Managing Committee

In the territorial funds and guild funds the representatives of the employers and the insured persons in the delegate meeting elect the members of the managing committee from among themselves in their respective groups, the employers electing one-third and the insured persons two-thirds (section 335). In guild funds, however, if the employers and the insured each bear half of the contributions, they each have half the representatives on the managing committee (section 341).

In works funds the managing committee consists of the employer or his representative, and representatives of the insured. As in the delegate meeting, the employer has half the number of votes granted by the rules to the insured persons (section 338).

The members of the managing committee of a territorial fund elect their president from among their own number at a joint election (section 328). The president of the managing committee of a guild fund is chosen by the guild from among the members of the committee (section 341). In works funds the employer or his representative acts as president (section 338).

The managing committee manages the fund (section 342). It represents it in courts of law and extra-judicially (section 5). If any decision of the administrative bodies of an insurance institution are contrary to the law or the rules, the president of the managing committee contests it by an appeal to the supervisory authority and this appeal effects a stay (section 8).

The managing committee is bound to give the industrial inspection official's on request information on the number and nature of cases of sickness (section 343)

Salaried Employees and Officials

The appointment of the officials and salaried employees of the funds is within the competence of the managing committee (section 349).

Service rules govern the legal position and general conditions of service of the persons employed by the funds, and in particular the proof of their technical qualifications, their number, their duties, the cancellation of their contracts, dismissal, and the imposition of penalties (section 352). The rules must also contain a scale of salaries (section 353). They are drawn up by the managing committee, which must first consult the adult salaried employees (section 355). They must be approved by the delegate meeting (section 346(1)) and the Superior Insurance Office (section 355, subsection 2).

COST OF ADMINISTRATION

The following table shows the proportion of administrative expenditure to total expenditure and benefits in 1914 and 1915, 1919, 1921, 1924, and 1925.

ADMINISTRATIVE EXPENSES PER CENT OF TOTAL EXPENDITURE AND BENEFITS

Year ¹	Administrative expenses per cent. of	
	total expenditure	expenditure on benefits
1914 ²	9.5	10.7
1915 ³	9.8	11.1
1919 ⁴	10.5	11.9
1920	10.5	11.9
1921	9.6	11.8
1924	7.3	—
1925	6.8	—

¹ Owing to inflation the statistics for 1922 and 1923 were not compiled

² These figures do not include the results for the general local funds for the town of Goldberg, the rural districts of Goldberg-Haynau and the Thann Insurance Office.

³ Including the Thann Insurance Office.

⁴ New territory, with Upper Silesia.

The actual expenditure per insured by type of fund is shown below:

ADMINISTRATIVE EXPENSES PER INSURED BY TYPE OF FUND

Year ¹	Local funds	Rural funds	Works funds	Guild funds	Total
	Marks	Marks	Marks	Marks	Marks
1914 ¹	4.01	2.36	0.54	4.38	3.04
1919 ¹	10.41	5.13	0.75	10.58	7.46
1920	25.37	12.47	1.94	23.53	18.49
1921	38.97	21.21	3.09	37.97	29.03
1924	—	—	—	—	3.6
1925	—	—	—	—	4.5

¹ See notes to previous table.

The cost of administration was lowest in the works funds owing to the fact that it was met almost entirely by employers. In 1925 the absolute cost of administration per insured person was slightly higher than in 1914

MINERS' INSURANCE

This branch of insurance, which is intended to grant miners the invalidity pensions and allowances to dependants specified in the Act of 1 July 1926, the benefits under the workers' insurance system with the exception of the accident insurance scheme, and the benefits under the salaried employees' insurance scheme, is administered by the Federal Miners' Benefit Society (*Reichsknappschaft*) and its local organs, the district mining funds (*Bezirksknappschaften*) and special sickness funds (*besondere Krankenkassen*) (sections 6, 7 and 9).

The constitution of the Federal Miners' Benefit Society is determined by its rules, but must be approved by the Federal Minister of Labour (sections 11 and 12). The Federal Society establishes the district and special funds (section 9). These special funds may not be established unless the following conditions are satisfied.

- (1) Where the establishment of the single fund for the whole district would give rise to serious inconvenience on account of special economic conditions or the distance of the undertaking from the headquarters of the district fund
- (2) Where the number of insured persons usually employed in the area and other circumstances are a sufficient guarantee of the solvency of the fund
- (3) Where the solvency of the district fund is not imperilled.
- (4) Where the majority of the insured persons, of the employers, and of the representatives of insured persons on the managing committee of the Federal Society are in favour of the establishment of a special fund (section 18).

Every district mining fund is administered by a district meeting and a managing committee with the assistance of the seniors of a mining fund and the seniors of a salaried employees' fund (section 65).

The election of the seniors (*Knappschaftsalteste*) takes place by direct ballot vote, in accordance with the principles of proportional representation, in the electoral groups formed in the area of each fund by the adult insured workers in possession of their civil rights, from among whom the candidates are chosen. It is the duty of the miners' seniors to supervise the observance of the rules and special regulations by the insured workers and to safeguard the interests of the workers as against the Federal Miners' Benefit Society (section 167).

The organs of management consist as to 2/5 of employers' representatives and as to 3/5 of representatives of the insured (section 169).

The representatives of the employers in the district meeting are elected by the employers from among their own number, and the representatives of the insured persons are elected by the miners' seniors and salaried employees' seniors from among their own number, in accordance with the principles of proportional representation (section 177).

The representatives of the employers on the managing committee and their substitutes are elected by the employers in the district meeting, and the representatives of the insured by the seniors in the district meeting. Not less than two-thirds of the representatives of the insured persons must be miners' seniors or salaried employees' seniors (section 171). It is the duty of the district meeting: (1) to elect representatives for the general meeting of the Federal Miners' Benefit Society; (2) to issue and amend the special regulations; and (3) to elect a committee to audit and approve the annual accounts of the sickness fund (section 178).

The conditions of service of all officials of the Federal Miners' Benefit Society, mining benefit funds, and the special sickness funds are defined by service rules (section 185).

GREAT BRITAIN AND THE IRISH FREE STATE

Under British and Irish legislation any body of persons, whatever their number, may form a society for administering compulsory sickness insurance, provided that it is approved by the competent authorities. In Great Britain this approval is granted by the Minister of Health, whose powers as regards Wales are exercised through the Welsh Board of Health, in Scotland by the Scottish Board of Health, and in the Irish Free State by the Irish Insurance Commissioners.

Every approved society and every society applying for approval must give security to provide against any malversation or misappropriation by officers of the society of any of its funds, unless it can prove that the only funds coming into its hands are such as are required for contributions previously expended by the society under the Health Insurance Act (section 55 of the British Act of 7 August 1924, section 26 of the Act of 16 December 1911 in force in the Irish Free State).

No society can be approved unless it satisfies the following conditions

- (1) It must not be carried on for profit.
- (2) Its rules must provide for its affairs being subject to the absolute control of its members who are insured persons
- (3) If the society has honorary members, its rules must provide for excluding such members from the right of voting on all questions and matters arising under the Act (section 29, subsection 2 of the Act of 1924, section 23, subsection 2 of the Act of 1911).

The rules are usually drafted by the body of persons who propose to form an approved society. The large majority of societies have adopted rules based on the model rules prepared by the authorities for supervising insurance institutions. The work of examining draft rules was particularly heavy when the Act came into force. In Great Britain the number of new associations formed is very small if a certain number of amalgamations are left out of account. Similarly, in the Irish Free State no new society has been set up since 1923, in which year, owing to the separation of the Irish and Britain systems, a fairly large number of sets of rules were approved.

Once a society has been approved, that is to say, its constitution and rules have been found to comply with the law, the competent authorities cannot require it to amend its rules on any particular point. On the other hand, a society, as approved, may not amend its rules without the authorisation of the central authorities. Rules inconsistent with the Act and Regulations are void. Approval may be withdrawn if the society fails to comply with the provisions of the Act or on account of maladministration (section 38 of the Act of 1924; section 29 of the Act of 1911). It may be of interest to observe that the report of the Royal Commission on National Health Insurance (pages 110-112) expressed the view that the central authorities should have more power to amend the rules when these tend to injure the insured. On the other hand, it is considered that they should have, in addition to the right to withdraw approval, that of imposing lesser penalties in cases of maladministration which do not justify complete withdrawal.

The method of administering approved societies differs according as the society is a centralised institution or has branches. The simplest case is that of a centralised society of a more or less local character.

The rules usually provide for the constitution of the following bodies: the general meeting and the committee of management, and for the election of trustees, a treasurer, and a secretary.

General Meeting

The general meeting may consist of all the members of the society or of their elected representatives. It must meet at least once a year, but exceptionally at longer intervals. In societies where the general meeting consists of all the members, voting by post may be adopted for certain specified questions.

The functions of the meeting include those of electing the committee of management, adopting the annual report of the society, and amending the rules. Any such amendments must be approved by the central authorities.

The meeting cannot take decisions unless a specified number of members are present. The quorum fixed by the rules of the British approved societies varies from one society to another. Thus, societies with a membership of 50 may be found which fix a quorum of eight members, and others with a membership of a million fixing a quorum of only 50.

Committee of Management

This committee is elected by the general meeting. The number of its members is fixed by the rules and usually varies between six and twelve. The duty of the committee is to transact the business of the society and invest its funds. In certain societies, for instance, the Irish county societies and the employers' provident funds, a proportion of the members of the committee (as a rule one-quarter) is appointed by the county council or the employer.

Officials

The general meeting also elects the trustees, a treasurer, and a secretary.

The trustees are *ex-officio* members of the committee of management, and are responsible for the safe custody of the assets of the society (deeds, documents of title, securities, etc).

The treasurer and the secretary have the right to attend the meetings of the committee of management, but may not vote. The secretary is responsible, under the superintendence of the committee, for the administration of the society and the payment of claims for benefit.

In addition, the large insurance companies which undertake national health insurance employ agents placed in different localities who are responsible, on the one hand, for paying cash benefits in respect of sickness insurance and, on the other, for carrying on the affairs of the company.

COST OF ADMINISTRATION

The administrative expenditure of approved societies is fixed at a flat rate for each insured person. If the sums provided for administrative expenses have not been spent during the year the surplus is credited to the administration account for the following year. If, on the contrary, there is a deficit which exceeds 6d. per member, a special levy may be imposed on the members. Those members who fail to pay the sums in question within the prescribed period may be punished by the reduction, postponement, or suspension of benefits (section 73 of the Act of 1924, section 17 of the Act of 6 February 1918 in force in the Irish Free State; and pars. 45 to 48 of the Approved Societies Regulations, 1924).

From 1918 to 1919 the maximum administrative expenditure per member was 3s. 5d. This was raised to 4s. 5d. in 1920 and 4s. 10d. in 1921. In 1924 it was again reduced to 4s. 5d.

Since 1921 a supplement of $\frac{3}{4}$ d. per insured person a year is fixed for societies granting additional cash benefits¹ and 5 per cent. of expenditure on benefits in kind. The average cost of administration in the Irish Free State per insured person was 4s. 1d. in 1925.

The total cost of administration of approved societies in Great Britain was as follows from 1922 to 1925:-

	£
1922	3,306,700
1923	3,382,500
1924	3,381,500
1925	3,441,200

¹ ROYAL COMMISSION ON NATIONAL HEALTH INSURANCE *Evidence*, App., Part I, p. 68.

² Annual reports of the Ministry of Health and the Scottish Board of Health

In the Irish Free State it was £89,233 in 1925

The following table shows the cost of administration of approved societies and insurance committees in Great Britain from 1914-1924

ADMINISTRATIVE EXPENDITURE OF APPROVED SOCIETIES AND INSURANCE COMMITTEES

Year	Cost of administration		
	Total	Per insured	Per cent. of total expenditure
	£	£	
1914	2,313,000	0.17	13.3
1915	2,475,000	0.17	15.8
1916	2,442,000	0.16	15.7
1917	2,391,000	0.16	15.6
1918	2,515,000	0.16	14.8
1919	2,946,000	0.19	15.1
1920	3,666,000	0.24	14.0
1921	3,900,000	0.23	13.4
1922	3,745,000	0.25	12.6
1923	3,780,000	0.25	12.8
1924	3,804,000	0.26	12.3

GREECE

It is compulsory for an employer to set up a works fund if his undertaking has been in existence for three years and he employs a permanent staff of 70 or more persons. Undertakings of this kind have the right to set up joint funds (section 4 (A), subsections 3 and 6 of Act No. 2,868). A similar provision applies to the Greek chambers of commerce and industry, which must set up a joint insurance fund for their salaried employees within six months of the coming into operation of the Act of 1923 (section 4 (A), subsection 5).

Every institution set up under the Act may sue and be sued (section 5), and is managed by an administrative council in accordance with the provisions of its rules, which must be approved by the Minister of National Economy. In the pension funds of specified undertakings and mining undertakings one-third of the administrative council consists of representatives of the undertakings and two-thirds of representatives of the insured persons (section 6).

The Act contains no detailed provisions on the constitution and working of other sickness institutions.

HUNGARY

Sickness insurance is in the hands of the National Workers' Insurance Fund, acting through its local organs, the district funds, and works funds. The mining funds, the tobacco factory, railway, post and telegraph, and inland navigation funds and the Francis-Joseph Hospital Fund are independent of the National Fund.

The territorial funds (district funds) are set up by the State administration authorities (section 119 of Act No. XIX of 7 April 1907). The National Insurance Office fixes the number, area, and headquarters of the district funds after consulting the management of the National Workers' Insurance Fund. During the communist regime, the work of the National Office was suspended, and since then its administrative powers have been transferred to the Ministry of Social Welfare and Labour. Since 1919 there has been no change in the number and area of the district funds.

The initiative for setting up works funds is taken by the employer. Any manufacturer or employer owning one or more undertakings in which not less than 300 workers liable to insurance are employed must found a works fund (section 138). Order No. 8,254 of 1921 supplemented the Act by laying down that in future works funds may be set up only if they are particularly suited to the needs of their members and do not imperil the working of existing district funds and private funds. An employer employing less than 300 persons may not be compelled to set up a works fund unless his undertaking involves serious risk of accident or sickness (section 139, subsection 1).

The Act of 1907 dissolved the guild funds and private mutual benefit funds set up under Act No. XIV of 1891 which had not been in operation for at least one year since the Act came into force and had a membership of not more than 800 during the last year. New mutual benefit funds may not be founded. The only two in existence are the Francis-Joseph Hospital Fund and the Debreczen Commercial Employees' Fund.

Order No. 9,210 of 1923 granted an insurance monopoly for water transport undertakings to the sickness insurance fund of the Water Transport Union.

The National Workers' Insurance Fund is an independent organ of workers and their employers (section 103). Under the Hungarian law, neither this Fund nor the district or works funds, which are its subsidiary organs (section 100, subsection 2), nor the mutual benefit societies can be considered associations within the meaning of the Commercial Code (section 202). They are therefore exempt from all stamp duties, real estate duties, taxes on earned income, unearned income and dividends, supplementary income taxes, etc. (section 303), and from all postal charges in their correspondence with the authorities (section 204).

THE NATIONAL WORKERS' INSURANCE FUND

The object of the National Fund is to insure workers against sickness on a mutual basis, to apportion the costs among employers and insured persons by fixing the rates of contribution in proportion to the needs of the district, to adopt uniform rules for the granting of benefits, to appoint medical practitioners and make arrangements for the supply of drugs and remedial appliances, to build hospitals and sanitary and convalescent homes, and to accumulate a reserve fund for defraying the costs of sickness occasioned by extraordinary circumstances (section 100). Its administrative bodies are the general meeting, the managing committee, and the supervisory committee (section 103).

General Meeting

The general meeting consists of the delegates elected by the separate groups of representatives of workers and employers in the general meetings of the district funds. Every fund must be represented by an equal number of employers' and workers' delegates. It is the duty of the general meeting to draw up and amend the rules, fix the wage classes and the rate of sickness benefit, give its opinion on increases or decreases of the rate of contribution, decide on the increase and appropriation of the reserve fund, decide on the construction of hospitals and convalescent homes, and in general decide on all questions affecting the health of the insured and involving the investment of considerable capital funds (sections 104 and 105).

Managing Committee

The managing committee consists of ordinary members and substitutes. Their number is fixed by the rules, and they are elected by the general meeting in proportion to the representation in the general meetings of the district funds and works funds. The representatives of employers and insured persons are elected from among their number separately in such a way that each group is equally represented on the managing committee (section 106, subsection 1).

Supervisory Committee

The supervisory committee is appointed by the general meeting, an equal number of members being elected separately by the employers' and workers' delegates (section 107).

By Order No. 4,790 of 1917, the independence of the National Fund was suspended, and no general meeting was to be held after 1 January 1918. By Order No. XXI of the Revolutionary Government, the participation of employers in management was abolished. By Order No. 3,679 of 1919, employers who held office in the National Fund or an insurance court on 21 March 1919 were reinstated.

Later, by Order No. 104,065 of 5 December 1919, the independence of the National Fund was again suspended in virtue of section 173 of the Act which gives the National Insurance Office the power to dissolve the independent bodies, to prohibit the re-election of members of the dissolved bodies, and to administer the Fund by its own representatives at the expense of the Fund whenever the administrative bodies of the Fund are constituted contrary to the law, or their management is contrary to the law or prejudicial to the interests of insurance or they engage in business outside the scope of the Fund.

DISTRICT AND WORKS FUNDS

The district fund acts as an intermediary for the local business of sickness insurance. It sees to it that the employers make the declarations prescribed by the law, keeps a register of compulsorily and voluntarily insured persons, provides for the apportionment and collection of contributions, pays benefits, provides for medical treatment and the supply of drugs, and makes arrangements for hospital treatment (section 118, subsection 1).

The administrative bodies of the district funds are the general meeting, the managing committee, and the supervisory committee.

The general meeting consists of delegates of the insured and their employers, elected separately, one-half from among employers and the other half from among the insured. The members of the managing and supervisory committees are elected from among the members of the general meeting, half by the employers' delegates and half by the workers' delegates. The managing committee deals with all matters not reserved by the rules to the general meeting (sections 125-127).

Similar provisions apply to the works funds, in which, however, the rules may permanently confer the chairmanship of the managing committee upon the employer or his representative (section 144). The employer is held liable for the proper management and regular working of the fund. If the resources of the fund are insufficient to defray current expenses, the employer must advance the necessary sums as a loan without interest which is repaid by the National Fund (section 146).

The position of the officials and salaried employees of the funds is determined by the rules (sections 109 and 130).

COST OF ADMINISTRATION

The cost of administration per insured person and per cent of total receipts from 1913 to 1914 and 1919 to 1924 is shown in the tables below.

COST OF ADMINISTRATION PER INSURED PERSON BY TYPE OF FUND

Year	All funds	District funds	Works funds	Mutual benefit funds	Francis-Joseph Hospital Fund
	Kr.	Kr.	Kr.	Kr.	Kr.
1913	4.48	5.31	0.02	5.83	—
1914	4.97	5.95	0.03	5.70	—
1919	35	36	0	51	40
1920	59	51	0.08	8.51	123
1921	91	101	0	194	116
1922	292	329	0.24	564	413
1923	3,375	3,784	5.62	—	4,142
1924	33,724	34,532	60.66	61,043	40,814

COST OF ADMINISTRATION PER CENT OF NET INCOME BY TYPE OF FUND

Year	All funds	District funds	Works funds	Mutual benefit funds	Francis-Joseph Hospital Fund
1913	15.4	18.7	0.1	15.4	—
1914	18.1	21.9	0.1	15.2	—
1919	13.9	14.7	0	23.2	10.3
1920	14.2	11.1	0	18.4	19.1
1921	12	13	0	24.8	9.8
1922	15.5	16.7	0	31.4	15.4
1923	8.1	9.3	0	14.3	6.7
1924	6	6.5	0	9	4.6

Before the war the cost of administration was comparatively high in all funds except the works funds and was highest in the district funds. During the period of inflation, the cost of administration fell considerably for the district funds. In 1923 and 1924, the proportion of income needed to cover administrative expenses was less than that for the pre-war period in every type of fund. The mutual benefit funds spent 14.3 per cent. and 9 per cent. respectively, of their income on administration, the corresponding figures for the district funds being 9.3 per cent. and 6.5 per cent., and for the Francis-Joseph Hospital Fund only 6.7 per cent. and 4.6 per cent. This marked reduction of administrative expenditure may be ascribed to the fact that the salaries of the employees of insurance institutions have not yet been raised.

IRISH FREE STATE

See Great Britain and Irish Free State

ITALY (New Provinces)

For the new Italian provinces the Legislative Decree of 29 November 1925 provided for the automatic establishment of territorial insurance funds with headquarters in the chief towns of each district (section 7, subsection 1). The Minister of National Economy may further authorise mutual benefit funds and works funds to undertake statutory insurance if the number of members is not less than 500, and the work of the fund is not likely to interfere with the development of the territorial funds (section 7, subsection 2).

These institutions have legal personality within the meaning of existing legislation and full legal powers (section 8, subsection 3).

Every territorial sickness fund is managed by an administrative council, appointed by Decree of the Minister of National Economy and consisting of nine members, of whom three represent employers and three insured persons and three are persons chosen from among social insurance experts living in the district in question. The president of the administrative council is appointed from among the three social insurance experts by Decree of the Minister of National Economy. The council elects from among its members two vice-presidents representing employers and insured. The term of office of the members of the council, who may be re-elected, is four years (section 12).

It is the duty of the administrative council:

- (1) To appoint the administrative, technical, sanitary, and supervisory staff.
- (2) To draw up the service regulations and instructions

- (3) To fix and modify insurance benefits.
- (4) To discuss the appropriation of moneys.
- (5) To perform any other work prescribed by the law or the rules (section 13, subsection 1).

Decisions taken under heads 2, 3 and 4 do not take effect until they have been ratified by the Prefect of the Province (section 13, subsection 3). If within the ten days following the deposit of the decision at the prefecture, no objection to it has been raised, the council may consider it as approved; otherwise an appeal may be taken within a fortnight to the Ministry of National Economy, whose decision is final (section 14 of the Administrative Regulations of 4 March 1926).

In addition a board of three auditors is appointed by the Ministry of National Economy for each fund, whose functions are defined by section 181 of the Commercial Code (section 9, subsection 4 of the Administrative Regulations of 4 March 1926).

JAPAN

According to the Act of 22 April 1922, territorial insurance offices are set up by the public authorities for each prefecture, and works funds by the employers concerned. Employers who employ over 500 insured persons are bound to set up a works fund and must obtain the approval of the rules by the competent Minister (sections 31 and 32). In undertakings employing from 300 to 500 persons, the establishment of a works fund is optional (section 28). An employer who wishes to set up such a fund must obtain the consent of the majority of the workers and submit his rules to the competent Minister for approval (section 29, subsection 1). Employers employing less than 300 persons may combine to set up a fund, provided that the total number of persons insured is not less than 300 (section 28, subsection 2).

All insurance institutions have legal personality (section 26).

The principal administrative body of the works funds is the delegate meeting, which must have at least 12 members, of whom half are appointed by the employer and half are elected by the insured persons from among the members of the fund (pars 19-20 of the Administrative Regulations of 30 June 1926).

The intervals at which the sessions of the meeting are held are not fixed by law. If one-third of the delegates so require, the meeting must be convened (par 27 of the Regulations). The chair is taken by the chief manager of the fund (par 28 of the Regulations). Half the total number of delegates constitute a quorum, except for decisions to amend the rules, in which case a majority of two-thirds is necessary (par 31 of the Regulations).

Among other things, the meeting decides on all matters connected with the estimates, the administration of the reserve fund, loans, the amendment of the rules, and the rates of contributions (par. 25 of the Regulations). It may transfer all or some of these functions to a special committee elected from among its members (par. 25 of the Regulations).

The number of officials of the funds, who are described in the Act as "managers," must be even and not less than four, two being appointed by the employers and two elected by the workers' representatives in the delegate meeting. The managers appointed by the employer choose the "chief manager" from among all the managers (section 36 of the Regulations).

LATVIA

See Esthonia and Latvia

LITHUANIA

GENERAL SYSTEM

The establishment of the district funds is in the hands of the Superior Social Insurance Office (section 2 of the Act of 9 December 1925 as amended on 25 September 1926). In places where not less than 150 workers are employed

or in undertakings employing not less than that number, branches of the district funds may be set up (section 5). The Act does not state whether such branches are established on the initiative of those concerned or of the Superior Social Insurance Office, but it is to be supposed that at the beginning the Office alone will decide on the expediency of setting up branches.

The district funds have legal personality (section 4) and are managed by the meeting, the managing committee, the audit committee, and the arbitration committee

Meeting

Two-thirds of the members of the meeting of the fund are representative of the insured and one-third representative of the employers. The total number may not exceed 45. The meeting is elected for a term of three years, and holds its ordinary sessions at least once a year. Its functions include those of electing the members of the managing, audit, and arbitration committees, adopting the annual financial report of the fund, amending the rules, examining complaints of the actions of the committee, entering into agreements with other funds, etc. (sections 108-118)

Managing Committee

Two-thirds of the members of the committee are representative of the insured and one-third representative of the employers. The maximum number of members is nine and the minimum six. They are elected for one year. Under the Act a representative of the Government may attend the meetings of the committee with the right to vote, as well as the manager, the chief medical officer, and a representative of the audit committee in an advisory capacity. It is the business of the committee to manage the affairs and assets of the fund. Its president represents the fund before the courts. The committee elects the manager of the fund and appoints the administrative employees, who are treated by the Act as State employees, and for whom every fund draw up service regulations (sections 119-154).

Audit Committee

The audit committee elected by the meeting consists of six members, of whom four represent the insured and two the employers. It is its duty to audit the accounts of the fund before the sessions of the general meeting and whenever it considers it necessary (sections 155 to 157).

Arbitration Committee

The arbitration committee consists of five members, of whom two are elected by the meeting from among representatives of the insured and two from among representatives of the employers. These four persons then designate the fifth member. The arbitration committee decides in any disputes between the insured and the managing committee arising in connection with benefits or with the penalties imposed on members of the fund who fail to observe medical instructions or are guilty of malingering (sections 158-181)

System in the Memel Territory

In the Memel Territory, where the German Social Insurance Code of 1911 (amended) is still in force, the only insurance institution, the Insurance Office (*Landesversicherungsanstalt*), was set up in 1922 when the territory was occupied by inter-allied troops. The administrative bodies of this Office are the delegate meeting and the managing committee.

The delegate meeting consists of 30 persons, 15 representing employers and 15 the insured, elected by the members of the meetings of the four local offices. Its functions include those of electing the members of the managing committee, adopting the financial report, approving the annual report, and amending the rules (sections 130-144 of the rules of 30 November 1922).

The managing committee consists of a president appointed by the Directorate for the territory, three representatives each of employers and insured, elected by the delegates of employers and insured in the meeting, voting separately. The managing committee, which has the standing of a public

administrative department, is responsible for managing the business of the Office except in the matters for which the meeting is competent (sections 112-129 of the rules)

LUXEMBURG

Insurance is administered by territorial and occupational funds. The first are funds set up by decision of the Government for specified areas. The Act provides for at least one in each Canton (except the Canton of Vianden), with its headquarters in the chief town of the Canton. It also provides for four funds in the Canton of Esch (section 26 of the Act of 17 December 1925).

The occupational funds are formed by employers. The head of any firm who employs regularly not less than 500 persons in one or more undertakings has the right to demand the establishment of an industrial fund for his workers (section 28). Before an industrial fund can be set up the consent of the Government is necessary its decision being taken on the recommendation of the central supervisory authority, the Central Committee, after consulting the local funds (section 28).

An industrial fund may not be set up if it compromises the existence and working of the regional funds. The criterion adopted is that the regional fund should still have over 500 members after the creation of the industrial fund. Further, the industrial fund must provide for benefits under its rules at least equivalent to those granted by the regional fund, and its permanent working must be adequately provided for (section 31). The Government decides, after consulting the Central Committee, whether the benefits granted by the industrial fund are equivalent to those of the regional fund for the district in question, account being taken of the total benefits and the special class of members of the fund (section 38).

Rules for the industrial fund are drafted by the employer and submitted to a meeting of the workers in the undertaking. The draft is then transmitted to the Central Committee, which in turn refers it together with its opinion to the Government for approval. Approval may not be refused unless the rules are not in accordance with the provisions of the law, and the reasons for refusal must be stated (sections 47 to 49).

The employers' funds which were in existence before the promulgation of the Act of 17 December 1925 were not allowed to continue their operations until they had obtained the authorisation of the Government, which consulted the Central Committee (section 32).

The administrative bodies of the fund are the general meeting and the managing committee.

General Meeting

In the territorial funds the general meeting consists of delegates elected by the employers and the insured. The employers or their representatives have one-third of the votes in the meeting and the insured or their representatives two-thirds. The number of votes of each employer is determined by the number of persons liable to insurance he employs. The rules may impose restrictions on this right and fix a maximum.

In the industrial funds the meeting consists of the employer and the delegates of the insured. The employer has the right to a number of votes equal to half the number granted to the insured by the rules (section 54).

Besides electing the representatives of the insured on the managing committee the general meeting deals with the matters outside the competence of the committee. The following subjects are reserved to it:

- (1) The compilation of the budget and approval of the annual financial report with the right to have the report previously audited by a special committee.
- (2) The representation of the fund as against members of the managing committee.
- (3) The conclusion of agreements and contracts with other funds.
- (4) The amendment of the rules.
- (5) The winding-up of the fund or its voluntary amalgamation with other funds (section 62).

Managing Committee

The managing committee of the territorial funds is elected by the general meeting. The employers and the insured or their representatives electing separately, the former one-third of the members of the committee and the latter two-thirds (sections 50-52). The members of the committee choose a president and vice-president from among their own number. If the president is an employer, the vice-president must be an insured person, and vice versa.

In the industrial funds the managing committee consists of the employer or his representative as president, a vice-president chosen from among the insured, and representatives of the insured. The employer has the right to appoint delegates to a number equal to half the number of representatives of the insured (section 53).

The managing committee represents the fund in courts of law and extra-judicially, and deals with current administrative business in accordance with the rules. It draws up the financial estimates and submits them at least two weeks before the meeting held for their adoption to the Government in order that the latter may state any objections, and if need be request the Central Committee to protest if the estimates are contrary to the Act, rules or regulations.

COST OF ADMINISTRATION

The provisions examined above are those of the Act of 17 December 1925. During the period 1913 to 1923, to which the statistics in the table below refer, sickness insurance was governed by the Act of 31 July 1901 as amended by the Acts of 9 February 1918 and 9 March 1918. The principal difference between the old and the new law lies in the disappearance of the mutual benefit funds as sickness insurance carriers. The table shows the cost of administration per insured person in the different types of the institutions

COST OF ADMINISTRATION PER INSURED PERSON IN EACH TYPE OF FUND

Year	Regional funds	Industrial funds	Mutual benefit funds
	Frs	Frs.	Frs
1914	4.39	0.79	—
1919	10.63	1.99	2.31
1920	13.86	1.20	2.01
1921	13.12	1.83	4.30
1922	12.95	2.13	3.29
1923	12.74	1.22	6.25

NORWAY

The initiative in setting up district sickness funds is taken by the communes. In accordance with section 40 of the Act of 6 August 1915, every commune must set up a public sickness fund, or if the communal authorities consider necessary, and the State Insurance Institution consents, several such funds. The creation of approved funds (works funds, trade union funds), which may take the place of public funds, needs the approval of the State Insurance Institution, which is not granted unless the rules of the funds contain provisions in accordance with the law (section 55) and they have not less than 200 permanent members. In the case of communal and works funds, however, the State Insurance Institution is given the right to approve them if they can rely on a permanent membership of 100 persons (section 56, subsection 1).

The substitute funds for teachers and railway employees are approved if they have a certain minimum membership and grant their members at least the benefits specified in section 54 of the Act.

The district funds are independent bodies with legal personality, and their liability is limited to their own property (section 42). Their administrative bodies are the general meeting, the managing committee, the auditors, and the manager.

General Meeting

The general meeting consists of the members of the fund and employers entitled to vote, and is convened at least once a year by the president of the managing committee (section 50, subsection 1).

The general meeting examines the rules drafted by the managing committee and any later amendments, all of which require the approval of the State Insurance Institution to be valid. Where occasion arises, it declares that the funds' employees and members of the managing committee are to be held liable. It examines the contracts concluded by the committee with the medical profession, dentists, etc. (section 51).

The rules may provide for the appointment of a representative committee to take the place of the general meeting (section 50, subsection 2). In this case they must contain the provisions concerning the number of members of this committee, their election, their term of office, the procedure of the committee, etc. In any case, two-thirds of the representatives must be elected from among the members of the fund entitled to vote, and the remaining third by the employers (section 52, subsection 2).

Managing Committee

The managing committee consists of nine members and nine substitutes appointed for a term of three years (section 44, subsection 1). The communal authorities appoint five members of the committee and their substitutes from among insured persons of over 21 years of age, and two members and their substitutes from among employers who are liable to contribute to the sickness fund and are over 21 years of age. There is no restriction on the choice of the remaining two members and their substitutes (section 44, subsection 2).

The election of the committee, whose term of office coincides with that of the communal council appointing it, takes place at the meeting at which the chairman and vice-chairman of the communal council are appointed.

The rules may provide that the managing committee shall consist of only five members and five substitutes. In this case the number of members elected from the respective groups are 3, 1, and 1 instead of 5, 2, and 2 (section 45). According to the model rules for district funds which came into force on 3 January 1916, the number of members of the committee was fixed at five, so that in practice the majority of the district funds have committees of five. Not more than fifty funds have obtained from the State Insurance Institution permission to amend this provision of the model rules and appoint committees of nine.

The committee, whose term of office begins on 1 January, appoints its president and vice-president for one year at a time (section 46). The president and members of the committee are re-eligible, but the retiring members may refuse to serve for the following term of office if they have served for two consecutive periods (section 47, subsection 1).

For the purposes of penal law the members of the committee are regarded as public officials. On the recommendation of the committee, the communal authorities may pay the president a suitable salary for his services at the expense of the district fund. The other members receive no remuneration for their services (section 48).

The committee meets on being convened by the president at least once a year and so often as it thinks necessary (section 49, subsection 1). In a general way the committee directly administers the fund, manages its property and represents it through the medium of its president in all litigation (section 49, subsection 3). It is also its duty:

- (1) To draft rules for the fund and any later amendments.
- (2) To submit the accounts to the communal council for approval.
- (3) To make recommendations concerning the salaries of the president and manager, to fix the salaries of other paid employees and appoint employees after consulting the manager.

- (4) To authorise expenditure on administration (section 49, subsection 2, amended in 1925)

Subject to the approval of the State Insurance Institution the managing committee may conclude agreements with medical practitioners, dentists, and midwives in accordance with the schedule fixed in section 16, subsection (1), A, (a).

The composition of the managing committee of the approved funds is determined by the State Insurance Institution. In the main it is the same as that of the district funds

For the teachers' substitute funds the composition varies with the class of person belonging to the fund (communal teachers' funds, national funds, district funds, funds for teachers in secondary schools, etc.). The largest group (communal funds) is managed by the education council, or a committee of three persons, one of whom belongs to that council

The railway employees' funds have committees of five to nine persons, of whom one, the permanent president, is designated by the central railway department.

Auditors, Managers and Employees

The auditors responsible for checking the accounts of the funds are appointed by the communal authorities (section 53, subsection 1). These authorities also appoint the managers and other permanent officials of the fund after consulting the managing committee. The appointments must be approved by the State Insurance Institution (section 53, subsection 1, amended by the Act of 10 December 1920).

For the purposes of penal law the manager and auditors are treated as public officials. The commune is responsible for the sums received by the manager and may require suitable security from him.

The manager conducts the daily business of the fund unless this duty is formally reserved to the committee by the law or rules. Decisions under the Act are taken by the manager, but, unless provided to the contrary, an appeal against his decisions may be taken to the committee of the fund (section 53).

COST OF ADMINISTRATION

The cost of administration, total and per member, and its percentage of total expenditure in the district funds were as follows in the period 1917-1925:

ADMINISTRATIVE EXPENDITURE OF DISTRICT FUNDS

Year	Administrative expenses		
	Total	Per member	Per cent. of total expenditure
	Kr.	Kr	
1917	1,460,268	3.08	11.0
1918	1,925,353	3.70	8.2
1919	2,609,571	4.80	8.3
1920	3,259,549	5.84	9.7
1921	3,253,527	5.93	9.2
1922	3,141,505	5.51	7.8
1923	3,052,952	5.27	8.7
1924	3,068,976	5.25	8.5
1925	3,111,171	5.22	8.0

The administrative expenditure of the district funds reached a maximum in 1920 and 1921. Since then there has been a reduction, both per member and in proportion to total expenditure.

The following table compares the administrative expenditure of the district funds with that of the approved funds in 1921 and 1925.

ADMINISTRATIVE EXPENDITURE OF EACH TYPE OF FUND

Type of fund	Administrative expenses					
	Total		Total per member		Per cent. of total expenditure	
	1921	1925	1921	1925	1921	1925
	Kr	Kr.	Kr	Kr		
Urban district funds	1,706 508	1,556,274	6 90	5 58	9 0	7 6
Rural district funds	1,547,019	1,654,897	5 14	4 90	9.3	8 4
All district funds	3,253,527	3,111,171	5 93	5 22	9 2	8 0
Approved funds	102,802	64,081	4 41	4.30	6.0	5 7

The administrative expenses of the approved sickness funds were thus lower than those of the district funds. The percentage expenditure on administration was about one-third less for the approved funds than for the district funds

POLAND

The constitution of the territorial funds is in the hands of the Minister of Labour and Social Assistance, who is responsible for the putting into operation and administering of the Act of 19 May 1920 (section 102)

The Act provides for the establishment of one territorial fund in each district and in each town with a population of over 50,000 (section 1). The Minister of Labour and Social Assistance decides the order in which sickness funds are to be organised within the territory of the Republic (section 104 (b)). Regional or municipal sickness funds already in existence are bound to bring their rules into conformity with the law (section 103, subsection 2). The funds set up under the German Insurance Code of 1911 have been maintained only in Upper Silesia.

The establishment of the occupational funds for State railway employees is also in the hands of the public authorities

The insurance institutions have legal personality. They have the power to acquire rights, contract obligations and sue or be sued in the courts. Their liability for their obligations is limited to their own property (section 2)

Each fund is managed by a delegate meeting, a managing committee, and a supervisory committee. It is also required to set up an arbitration committee to settle any disputes which may arise between the insured persons and the fund and a conciliation committee for disputes with medical practitioners.

Delegate Meeting

The meeting consists of delegates elected for a term of three years, two-thirds of whom represent the insured and one-third the employers. The delegates are elected by the insured and their employers separately by direct and secret ballot in accordance with the principles of proportional representation. Employers and insured persons of either sex who are over 20 years of age have the right to vote. Only Polish citizens who have the right to vote are eligible. Only members of the fund are eligible as representatives of the insured persons. The number of delegates may not exceed 90. The elections are conducted in accordance with the Regulations of 21 March 1921 as amended on 28 December 1923. The number of votes assigned to each employer is proportionate to

the number of persons liable to insurance he employs, subject to a maximum of 30 votes.

The meeting is convened at least once a year. Its decisions are valid if at least half the delegates of the insured persons are present. Its functions include

- (1) The election of the managing committee, the supervisory committee, and the arbitration committee.
- (2) The examination and approval of the annual report of the managing committee and the balance sheet.
- (3) Decisions on the conclusion of agreements with other funds
- (4) The amendment of the rules with the approval of the Insurance Office.
- (5) Decisions on all questions submitted for its consideration by the managing committee, in particular those respecting the establishment of hospitals, convalescent homes, and the acquisition and sale of real property.

The meeting takes its decisions by a simple majority, but a two-thirds majority is required for an amendment of the rules or an increase of contributions for the purpose of granting additional benefits (sections 62, 63, 65-67)

Managing Committee

The managing committee consists of not less than nine, and not more than eighteen, members, who are elected by the general meeting, the employers' delegates electing one-third, and the insured persons' delegates the other two-thirds. The committee is elected for a term of three years. One-third of the members for each group retires annually, in order of seniority, and other members are elected in their places.

The managing committee is responsible for the general management of the operations of the fund, its administration, and the use of its resources. It also decides in the first instance on all matters connected with the liability to insure, the duty of paying contributions, classification of the insured into wage groups, the apportionment of contributions between employers and insured, and the fines to be imposed on employers and insured persons (sections 68, 73, 76).

Supervisory Committee

The supervisory committee is elected by the delegate meeting for one year. It consists of six members, representing the insured and the employers in the same proportion as in the other administrative bodies of the fund.

Before each session of the delegate meeting and whenever the supervisory committee considers it necessary, it examines the work of the officers of the fund and checks the property, books and papers. If any decisions or actions of the administrative bodies of the fund are contrary to the provisions of the Act or the rules, the supervisory committee must notify the Insurance Office. The decisions of the supervisory committee effect a stay until the Insurance Office has decided, which decision must be taken within one month (sections 80-82)

COST OF ADMINISTRATION

According to a communication received from the Ministry of Labour and Social Assistance, the cost of administration of the Polish sickness funds was as follows in 1924:

TOTAL ADMINISTRATIVE EXPENDITURE OF SICKNESS FUNDS IN 1924 (IN ZLOTY)

Number of funds	Expenditure on staff	Expenditure on equipment	Total
135	6,881,706 54	2,415,137 23	9 296,843 77
19	310,868 40	108,573.35	419,441 75
154	7,192,574.94	2,523,710 58	9,716,285 52

COST OF ADMINISTRATION PER INSURED AND PER CENT. OF CONTRIBUTIONS

Number of funds	Expenditure on staff		Expenditure on equipment		Total	
	Per insured (in zloty)	Per cent of contributions	Per insured (in zloty)	Per cent of contributions	Per insured (in zloty)	Per cent. of contributions
135	4 92	8 38	1 72	2 9½	6 6½	11 22
19	—	12 10	—	4 2½	—	16 33
154	—	8 49	—	2 98	—	11 47

PORTUGAL

According to Decree No. 5,636 of 10 May 1919, compulsory mutual benefit institutions for sickness insurance must be set up in all districts on the mainland and the adjacent islands. In order to promote the registration of the members and to provide for more speedy assistance for the sick, the institutions may set up branches or agencies in more densely populated parishes (section 2).

The initiative for establishing these institutions is taken by the State, which, through the medium of the Institute of Social Insurance and Public Welfare, is competent to organise insurance, instructing the census officials in each parish to make a census of all persons liable to compulsory social insurance (section 11)

In districts where mutual benefit societies are already in existence these had the right to transform themselves into compulsory institutions within 60 days of the date of promulgation of the Decree (section 8)

Once the Institute of Social Insurance and Public Welfare has published in the *Official Gazette* the Decree approving the rules of a compulsory insurance institution, the latter enjoys the following privileges. It may sue and be sued in the courts, and is entitled to legal assistance. With the previous approval of the Government, it may own the necessary urban real estate for its premises, administration, and branches. It is exempt from the payment of certain taxes and duties. With the previous approval of the Government, it may receive legacies exempt from liability for taxes. It is also exempt from postal charges (section 16)

The administrative bodies of the compulsory mutual benefit institutions are the general meeting, the managing committee, and the financial council (*conselho fiscal*).

General Meeting

The general meeting consists of the effectively insured members of the institution (persons between 15 and 75 years of age living in the district of the institution whose annual income is less than 900 escudos and who are entitled to insurance benefits) and the honorary members (members whose annual income is over 900 escudos)

The ordinary general meeting is held twice a year. The first, in January or February, has competence to examine, approve or alter the reports for the preceding year, and decide on the work of the managing committee; the second is held in November or December and has competence to elect the managing committee, the financial council and the officials of the institution (section 55, subsection 1). An extraordinary meeting may be convened, whenever its president, the managing committee, or the financial council consider this necessary, or at the request of 14 members, unless the rules fix a higher minimum (section 55, subsection 5)

The general meeting is also competent to amend the rules of the institution, but a decision of this kind needs a quorum of two-thirds of the members (section 56)

Any decisions taken by the general meeting contrary to the provisions of the Act or the rules are not binding on the institution as such, but the persons who took part in such deliberations are severally and jointly liable for their actions (section 58)

Managing Committee

The managing committee consists of a president, a secretary, a treasurer, and the number of members fixed by the rules (section 50). These persons are elected for one year by the general meeting from among the effectively insured members and the honorary members. The Act contains no provision fixing the proportion of the seats to be reserved for the honorary members, the decision resting with the electorate.

The members of the managing committee are severally and jointly liable towards the institutions and third parties for the performance of the obligations imposed on them (section 51).

The approval of the balance sheet and annual report by the general meeting discharges them from their responsibility towards the institution after a period of six months, unless it is proved that the balance sheets and accounts contain omissions or false statements, intended to conceal the true financial position of the institution (section 51, subsection 4).

Financial Council

The financial council consists of at least three members, one of whom acts as president and another as secretary. They are elected for a term of one year by the general meeting, which may revoke their mandate whenever it considers necessary.

The financial council has power:

- (1) To examine whenever it considers necessary, and at least every three months, the accounts of the institution
- (2) To convene the ordinary and extraordinary general meeting when it considers necessary
- (3) To attend the sessions of the managing committee
- (4) To supervise the administration of the institution by auditing its accounts
- (5) To give its opinion on the accounts and reports submitted by the managing committee.
- (6) To see to it that the provisions of the Act and the rules are observed by the managing committee (section 52).

ROUMANIA

Former Kingdom and Bessarabia

The Central Office for Crafts, Credit and Workers' Insurance is responsible for organising and administering the Sickness Insurance Fund for the territory of the former Kingdom and, since the promulgation of the Act of 9 April 1921, also for Bessarabia.

The Central Fund collects the moneys derived from the sale of stamps for contributions and the dues and fines specified in the Act on behalf of the Office, and distributes to its local organs, the guilds and mutual benefit societies the necessary sums for the payment of sickness benefit, funeral benefit, and administrative expenses (section 195, subsection 4 of the Act of 25 January 1912).

The guilds (*corporatia*), which are the primary insurance institutions, consist of groups of several brotherhoods (*breasla*) and must have a membership of not less than 1,000 (section 78). The brotherhood, an association of not less than 25 artisans in any one trade, consists of apprentices, journeymen apprentices, journeymen, factory workers who have been trained as artisans and persons who hold a master's certificate and work either on their own account or on behalf of another. It is compulsory for these persons to belong to a brotherhood (section 64, subsection 2). Manual labourers, workers who are not

artisans or have had no vocational training, if employed in factories, quarries or other industrial undertakings cannot belong to a brotherhood but only to the guild (section 2).

In addition to the group of insured persons in guilds, the Act provides for the creation of mutual benefit societies in State, departmental, and communal factories and undertakings (section 136). These also act merely as organs of the only insurance institution, the Central Workers' Insurance Office at Bucarest.

The Central Office approves the rules of the brotherhoods and guilds, as also of the mutual benefit societies. It examines the accounts of the guilds and mutual benefit societies and undertakes all the necessary financial operations for the investment of insurance moneys (sections 136 and 197).

The Office is administered by an administrative council of 13 members appointed by Royal Decree for a term of seven years, as follows:

Two members appointed by the Minister of Finance; seven by the Minister of Labour, Co-operation and Social Insurance; two employer members chosen by the competent Minister out of a list of six employers submitted by the Employers' Association; and two artisan or workers' members chosen by the competent Minister from a list of delegates, one for each guild elected by the general meeting of the guild (section 194, subsection 1).

The Director-General of the Office, assisted by a deputy director, is responsible for carrying out the decisions of the administrative council (section 204).

COST OF ADMINISTRATION

In the former Kingdom the cost of administration per cent. of total expenditure in the insurance institutions was as follows during the period 1912 to 1925:

ADMINISTRATIVE EXPENSES PER CENT. OF TOTAL EXPENDITURE

Year	Expenditure on staff	Expenditure on equipment
1912	0.94	16.50
1913	5.02	9.61
1914	7.39	13.83
1915	8.22	14.96
1916	9.09	18.43
1917	7.43	21.81
1918	7.03	19.52
1919	4.09	28.68
1920	1.80	15.86
1921	3.84	15.87
1922	4.29	18.14
1923	4.59	19.25
1924	6.35	22.53
1925	7.48	27.98

Ardeal

In Ardeal, formerly Hungarian territory, comprising Transylvania and the Banat, the constitution and working of insurance institutions are still subject to the provisions of the 1907 Act¹. The funds in this part of Roumania are directly attached to the Central Workers' Insurance Office at Bucarest.

COST OF ADMINISTRATION

The cost of administration per cent. of total expenditure in the insurance institutions was as follows during the period 1919 to 1925:

¹ See pp. 627-630.

ADMINISTRATIVE EXPENSES PER CENT OF TOTAL EXPENDITURE

Year	Expenditure on staff	Expenditure on equipment
1919	—	32.66
1920	—	15.73
1921	—	18.96
1922	10.91	8.04
1923	13.62	9.18
1924	14.40	10.66
1925	16.67	11.16

Bukovina

In Bukovina, formerly Austrian territory, the constitution and working of insurance institutions are still governed by the provisions of the Act of 30 March 1888 as amended¹.

COST OF ADMINISTRATION

The expenditure of the Bukovina insurance institutions on administration was as follows in 1922-1924:

ADMINISTRATIVE EXPENDITURE

Year	Total administrative expenses	
	Amount	Per insured
	Lei	Lei
1922	1,587,229	64.30
1923	2,026,161	64.76
1924	3,614,316	102.73

RUSSIA

The workers' trade union organisations take a direct part in constituting the sickness insurance funds, for they have competence to share in setting up the provincial (or regional) social insurance authorities on which the insurance funds depend.

Such funds must be set up for the area within a radius of two versts of the centre of each district, provided that the membership is not less than 2,000. By agreement between the provincial (or regional) insurance authorities and the inter-trade union organisation, an insurance fund may be set up for a smaller membership than 2,000 persons if it is impossible to place the undertakings in the area within the competence of another fund, or if in the area there are distinct economic units (factories) employing a considerable number of workers.

Provision is also made for setting up special local organisations (insurance offices or commissioners) for districts which are distant from an insurance fund, and where the number of insured is insufficient for the organisation of an independent fund. The territorial insurance funds are responsible for making these appointments in agreement with the provincial (or regional) social insurance authorities. The insurance offices are set up in districts or undertakings cover-

¹See pp. 610-612.

ing 200 to 2,000 insured persons, and commissioners are appointed for districts or undertakings covering 50 to 200 persons. In both cases the undertaking in question must be more than five versts distant from an insurance fund.

Transport workers (railway and water transport) have special insurance funds which are set up on the initiative of the transport workers' trade union conference. The main line insurance funds for the railways and the divisional insurance funds for the inland waterways may set up in the different districts special district insurance funds, which in turn may set up insurance offices or appoint commissioners.

The law also provides for the institution of special occupational funds for workers employed in construction especially in that of railways. These may not be set up unless the work is carried out at a distance of more than five versts from a territorial or transport fund, and the work continues for not less than two years and employs a considerable number of workers. Such funds are organised with the consent of the building workers' union, which must also give its opinion on the constitution of an insurance office or the appointment of a commissioner (Circular of Commissariat of Social Welfare and Central Committee of All-Russian Union of Constructional Workers, dated 13 December 1922, No. 248). If the work is transferred to a place which is covered by a territorial or transport fund (or their insurance offices or commissioners), the building workers' fund must be closed down, as also its subordinate organs.

The funds are responsible for administering insurance against all risks, and are managed by the local trade union conference, the managing committee, and the audit committee.

Conference

The composition and method of election of the conference are fixed by the local inter-trade union authorities. The functions of the conference are the following:

- (1) To fix the number of members of the committee and their substitutes, and conduct their election, as also that of the members of the audit committee any other committees.
- (2) To examine and adopt the reports of the committee and approve the financial reports of the fund.
- (3) To alter by previous agreement with the central social insurance authorities the rate of cash benefit.
- (4) To issue regulations and instructions for the managing committee, the other committees, and the insured persons in application of the rules of the fund.
- (5) To fix the order of inspection of the fund.
- (6) To amend the rules of the fund, etc.

Managing Committee

The immediate management of the fund is entrusted to a committee of from three to seven members, chosen by the conference, which may elect only persons who are entitled to take part in the conference. The number of members of the committee and their term of office are fixed by the rules of the fund. The president of the committee is elected by the committee from among its own members, and the election is confirmed by the provincial (or regional) social insurance authorities. An appeal against the decisions of the committee may be taken within one week to the provincial (or regional) social insurance authorities. Such appeals must be transmitted through the committee.

Audit Committee

The audit committee is elected by the trade union conference. The number of its members is fixed by the conference, but must not be less than three. The principal duty of the audit committee is to supervise and check the financial,

economic, and administrative activities of the insurance fund. Inspection reports are submitted by the audit committee to the managing committee of the fund; any cases of negligence discovered by the audit committee are mentioned in these reports, and the committee, in agreement with the president of the fund, fixes a period within which the matter is to be remedied (Instruction of Commissariat of Labour of U.S.S.R., dated 25 March 1925, No. 87/618).

Insurance Offices and Commissioners

In districts which are more than five versts distant from a fund, an insurance office may be set up if the number of insured persons is from 200 to 2,000, or a commissioner appointed if the number is from 50 to 200.

The manager of an insurance office is appointed by the committee of the fund in agreement with the inter-trade union organisation. The commissioners are appointed by the insurance fund in agreement with the works committee. The staff of an insurance office must not be more than three persons; a commissioner has no technical staff.

It is the duty of the insurance offices:

- (1) To receive applications for benefits and pensions.
- (2) To supervise insured persons suffering from temporary incapacity and unemployed workers.
- (3) To enquire into the means of persons who claim or are in receipt of a pension.
- (4) To pay benefits and pensions.
- (5) To distribute in obvious cases allowances for temporary incapacity.
- (6) To keep a record of the undertakings and establishments employing paid workers.
- (7) To supervise the regular payment of insurance contributions.
- (8) To collect insurance contributions in places which are distant from credit institutions, and to pay the contributions to the insurance fund at least twice a month, supplying the necessary documents.
- (9) To supply information on social insurance to insurers and insured.
- (10) To supervise the provision of medical attendance for the insured, and participate in all enquiries for developing and improving this form of benefit.
- (11) To carry out all other measures adopted by the insurance fund.

It is the duty of the commissioners:

- (1) To receive applications for benefits and pensions.
- (2) To pay benefits and pensions.
- (3) To supervise the regular payment of insurance contributions.
- (4) To carry out all other instructions of the insurance funds.

The work of the insurance commissioners is performed outside ordinary hours of work, and is paid for out of the sums granted for the maintenance of works committees. (Decision of Commissariat of Labour of U. S. S. R., dated 21 August 1923, No. 73/75.)

COST OF ADMINISTRATION

The sums to be applied for meeting the cost of administration are fixed beforehand and submitted for the approval of the higher insurance authorities before the beginning of the financial year (Instruction of the Federal Social Insurance Council, dated 23 June 1927, No. 194).

Further, in all funds 1 per cent of the sums paid for medical attendance may be spent on administration.

The greater part of these sums has been used to defray the cost of salaries of officials and employees of the institutions. The number of employees of the insurance funds in 1923 was approximately as follows:

Number of funds	Membership	Number of officials	
		Total	Per thousand insured
347	1,865,135	3,523	1.9

Thus, in 1923, there was one official to about 530 insured persons, but the proportion varied considerably from one region to another (at Novo-Nikolaevsk, one official to 317 insured persons; at Astrakhan, one to 711 persons).

In 1924 there was one official to a number of insured persons varying between 466 and 790.

In January 1925¹ there were 13,500 officials in all, of whom 2,824, or 21.8 per cent., were employees of the transport funds. On an average there were 19.7 employees in each territorial fund and 11.3 employees in each transport fund. In the R. S. F. S. R., the average number of officials per fund was as follows:

Membership of fund	Average number of officials
Up to 2,000	4.3
2,000 to 3,000	6.4
3,000 to 5,000	9.9
5,000 to 10,000	15.3
10,000 to 20,000	28.8
20,000 to 30,000	43.3
30,000 to 40,000	66.3
over 40,000	115.8

The funds thus had on an average one official for every 477.9 insured persons (one official for every 501 insured in the territorial funds, for every 392 in the railway transport funds², and for every 284.5 in the water transport funds). In the Ukraine the insurance institutions employed on an average one official for every 600 members. On 1 October 1926 there was 1 official to 451 insured in the R. S. F. S. R., and 1 to 649 in the Ukraine.

The salaries of the officials in December 1924 amounted to 863,000 roubles, exclusive of bonuses. The average salary was 66.63 roubles a month, or about 1.45 times as much as the average earnings of insured persons. The average salary varied between 57.88 roubles in the Ukraine and 83.77 roubles in the Crimea. The absolute maximum was reached in the water transport funds with 92.75 roubles a month per employee.

In 1924-1925 (six months period) the cost of administration of the social insurance institutions was 9,379,755 roubles, or 161.56 roubles per 100 persons insured. The expenditure represented about 6.37 per cent. of the total income of the institutions. In the R. S. F. S. R. the average expenditure on administration was 5 per cent. of the total expenditure and 3.9 per cent. of the receipts of the funds in 1925-1926.

¹ *Voprosy Strakhovaniia* 1925, No. 32, p. 5.

² A more recent official report (*The Insurance Conference of April 1926*) gives the number of officials in the transport funds as 2,560, or 1 official for every 500 members (*Voprosy Strakhovaniia*, 1926, No. 17).

SERB-CROAT-SLOVENE KINGDOM

The establishment, number, area, and headquarters of the local workers' insurance institutions are fixed by the general meeting of the Central Workers' Insurance Institution, subject to the approval of the Minister of Social Affairs (section 141 of the Act of 14 May 1922).

Every transport undertaking whose operations extend over the districts of two or more local institutions and which employs more than 1,000 workers liable to insurance, is bound to set up a special insurance fund for its workers (section 153, subsection 1). If such an undertaking fails to fulfil this obligation, the managing committee of the Central Workers' Insurance Institution may adopt a resolution, ordering the establishment of the fund (section 153, subsection 2). Further, two or more transport undertakings have the right to set up a joint workers' insurance fund (section 153, subsection 3).

Mutual benefit societies may be set up for workers in mining undertakings, subject to the same provisions as apply to the insurance funds for transport undertakings, provided that the number of workers employed is over 2,500 (section 158).

The Act specifies that the Central Workers' Insurance Institution is the sole insurance carrier and that the local insurance institutions, the insurance funds for transport undertakings and the miners' mutual benefit societies are only its local organs (section 119). The Central Institution and local institutions are public bodies, organised on the principle of autonomy (sections 124 and 143). A local institution may accept liabilities and acquire rights within its competence as defined by the Act and the rules of the Central Institution. The funds for transport undertakings and the miners' mutual benefit societies, on the contrary, are not deemed to be public bodies (sections 154 and 158, subsection 2).

THE CENTRAL WORKERS' INSURANCE INSTITUTION

The chief duties of the Institution with respect to sickness insurance are as follows:

- (1) To administer sickness insurance in accordance with the principle of mutual aid, and for this purpose to fix the insurance contributions and pay the benefits and allowances prescribed by the Act.
- (2) To organise the collective employment of medical practitioners and the collective purchase of medicines and requisites for treatment.
- (3) To set up pharmacies, hospitals, dispensaries, and convalescent homes.
- (4) To form a reserve fund for sickness insurance (section 122).

The administrative bodies of the Central Institution are the general meeting, the management and the supervisory committee (section 124).

General Meeting

The meeting consists of an equal number of representatives of the workers and employers in the general meetings of the local institutions elected by the insured persons and employers separately from among themselves (section 125). Representatives at the general meeting must be nationals of the Serb-Croat-Slovene Kingdom. No person is eligible who has not attained the age of 18 years, is under guardianship, or in bankruptcy, or has been sentenced by a court of law on account of a crime or misdemeanour committed for purposes of gain (section 131, subsection 1).

The functions of the general meeting include:

- (1) Drawing up and if need be amending the rules of the Central Institution.
- (2) Fixing the benefits to be paid and deciding on their increase or reduction.
- (3) Deciding on the manner in which the costs of insurance are to be met and for this purpose fixing the insurance contributions.
- (4) Deciding on the utilisation of the sickness insurance reserve fund.
- (5) Deciding on the establishment of hospitals, sanatoria, and pharmacies.
- (6) Deciding on the purchase and sale of real property and the acceptance of liabilities involving a considerable charge (up to 1,200,000 dinars) on the Institution (section 126 of the Act and section 50 of the rules).

Decisions concerning the rates of benefits and contributions are not valid unless adopted by a secret vote resulting in a two-thirds majority of the representatives present at the general meeting. Decisions on the amendment of the rules, the rates of benefit, and contributions must be approved by the Minister of Social Affairs. If a two-thirds majority cannot be obtained when the sickness benefit is first fixed, the rate is determined by the Minister (section 126, subsection 2)

Management

The management is elected by the general meeting (not more than 36 members) in such a way that the various categories of employers and workers are represented in their due proportions. The rules of the Institution (section 51) fix the number at 24 (12 employers and 12 workers).

The management elects the chairman from the employers' and workers' representatives alternately in rotation, who also presides at the general meeting.

All matters not reserved by law or the rules to the general meeting and other administrative bodies of the Central Institution are within the competence of the management (section 127)

Supervisory Committee

The supervisory committee consists of three representatives each of employers and insured persons (section 128 of the Act and sections 81-82 of the rules)

The supervisory committee is responsible for the observance of the Act, Decrees, and other regulations on workers' insurance; it examines the balance sheet and accounts; it refers to the management, the general meeting, and, if need be, the Minister of Social Affairs any illegal or improper actions of which it may learn (section 83 of the rules).

LOCAL WORKERS' INSURANCE INSTITUTIONS

The duties of the local institutions with respect to sickness insurance include the following:

- (1) Seeing to it that employers fulfil their duty of notifying the persons they employ.
- (2) Keeping the register of insured persons
- (3) Prescribing and receiving contributions and seeing to it that they are collected.
- (4) Granting cash benefit and medical treatment, and if need be ordering treatment in curative institutions
- (5) Keeping the necessary records for compiling morbidity and mortality statistics (section 139, subsection 1).

The administrative bodies of the local institutions are the general meeting, the managing committee, and the supervisory committee.

General Meeting

The general meeting consists of an equal number of representatives of employers and insured, elected by the employers and insured persons concerned. The functions of the general meeting include those of electing the members of the managing committee and the supervisory committee, the delegates to the general meeting of the Central Workers' Insurance Institution and the assessors of the social insurance court. It must also approve the annual budget and accounts, and decide on the organisation of medical treatment, namely, whether the insured are to be treated by permanent medical officers attached to the institution or by the doctors freely chosen by the insured (sections 139 et seq.).

Managing Committee

The managing committee of the local institutions consists of 12 members, half elected by the employers' representatives and half by the insured persons' representatives in the general meeting. It is responsible for conducting the ordinary business of the institution, and for this purpose engages the staff

of the institution and where necessary the medical officers (sections 166-169 of the rules).

Supervisory Committee

This committee consists of two members representing employers and two the insured persons. Its duties are the same as those of the supervisory committee of the Central Workers' Insurance Institution. The committee must inform the managing committees of the local and central institutions and the general meeting of the local institution of any irregularities which they may have observed in the management of the local institution (sections 170 and 173 of the rules).

The provisions concerning local institutions apply to the transport funds set up under sections 153 and 157 of the Act, and to the two special funds for private employees at Zagreb and Ljubljana (sections 174 and 176 of the rules).

SWITZERLAND

The Federal Act of 13 June 1911 empowered the Cantons to make sickness insurance compulsory in general or for certain groups of persons. For this purpose the Cantons were made competent to set up public funds, due account being taken of existing mutual benefit funds. The powers of the Cantons in this respect may be transferred to their communes. All measures of this kind taken by the Cantons and communes must be submitted to the Federal Council for approval (section 2).

In the Cantons which have made use of their powers under the Federal Act, the initiative for setting up mutual benefit funds is taken by those concerned, and for public funds by the Cantonal or communal authorities.

Any mutual benefit fund which desires recognition must submit its rules to the Federal Council for approval, as well as any other regulations governing the rights and obligations of their members. Recognition is granted only if they provide medical treatment or medicines for their members, or a daily unemployment benefit of not less than one franc in case of absolute incapacity for work. All amendments of the rules must also be submitted to the Federal Council for approval (sections 4 and 12).

The establishment of public cantonal or communal funds is within the competence of the public authorities. In the Cantons of Appenzell, Inner Rhodes, and Basle Town, the initiative for setting up public funds is taken by the cantonal authorities (Order of 29 November 1920 for Appenzell, Inner Rhodes, section 1, setting up two public funds, and the Act on the public fund of the Canton of Basle Town dated 12 March 1914, as amended by the Acts of 10 October 1918 and 23 February 1922). In the Canton of Appenzell, Outer Rhodes (the Order of the Council of State of 13 May 1924 promulgated in pursuance of the Act of 30 April 1916 as amended on 30 April 1922), in the Canton of St. Gall (Act of 28 May 1914 on compulsory sickness insurance and communal funds, amended by the Act of 28 November 1919), and in the Canton of Thurgau (Compulsory Sickness Act of 24 April 1926) it is taken by the communes, which if they are not in the position to set up the funds alone, may combine with other communes to organise a joint sickness fund.

The public funds are considered to be independent branches of the administration with separate accounts (section 2 of the Appenzell, Inner Rhodes, Order of 28 November 1920; section 21, subsection 2 of the Appenzell, Outer Rhodes, Order of 13 May 1924; section 6, subsection 3 of the St. Gall Act of 28 May 1914). The Act on the public sickness insurance fund for the Canton of Basle Town of 12 March 1914 contains a similar provision.

The public funds are managed as follows

Appenzell, Outer Rhodes

The administration of the communal public funds is in the hands of the communal council, which must appoint for each fund a committee on which the communal council and the compulsorily insured persons are represented. Women are also eligible for these committees (section 21 of the Compulsory Insurance Act of 30 April 1916).

Appenzell, Inner Rhodes

The two cantonal funds are administered by a committee of seven members in which each district is represented by one delegate (the district of Appenzell by two) appointed by the district council, and the insured persons also by one delegate (section 6 of the rules). The administration of the Oberegg fund may be entrusted to the district council. The supervision of the persons liable to insurance, the collection of contributions, and the accounts are in the hands of an accountant appointed by the committee (section 19 of the Act of 29 November 1925).

Basle Town

The public fund is administered by the Board of Health, a committee of six, of whom three are insured persons, being attached to the Board for the purpose. This committee is appointed for a term of three years by the Council of State. The President of the Board of Health is *ex-officio* president of the committee (sections 25 and 26 of the Act of 12 March 1914, as amended on 10 October 1918 and 23 February 1922).

St. Gall

The provisions are the same as for the Canton of Appenzell, Outer Rhodes (section 8 of the Act of 28 May 1914 as amended on 28 November 1919).

Thurgau

Same provisions as in the Canton of Appenzell, Outer Rhodes (section 17 of the Act of 24 April 1926).

§ 4. — Federations of Institutions

OBJECT OF FEDERATION

Where a compulsory sickness insurance system establishes a large number of insurance carriers, it is particularly difficult to carry out any work which requires an institution with a larger membership and funds than a single insurer can provide. Consequently, several laws provide for the possibility of forming federations or associations of funds, grouping the various institutions for purposes of co-operation.

Such groups are unnecessary in countries where there are central insurance institutions acting as the sole insurance carriers, the separate funds playing only the part of their local organs. To some extent these central institutions perform the duties of federations of funds and make the work of associations of insurers practically unnecessary. This is, for instance, the case under the laws on seamen's insurance in Belgium, miners' and seamen's insurance in France, miners' insurance in Germany, and in the sickness insurance systems of Bulgaria, Hungary, Russia, and the Serb-Croat-Slovene Kingdom.

In the following countries, on the contrary the law provides for the establishment of federations of funds: Austria, Czechoslovakia, Esthonia, France (Alsace-Lorraine), Germany, Great Britain,

Irish Free State, Italy (new provinces), Latvia, Lithuania, Luxemburg, and Poland.

The following duties, among others, are entrusted to federations of insurance institutions:

- (1) Supervision of the work of the separate funds (Poland) and engagement of joint supervisory agents (Austria).
- (2) Supervision of the payment of contributions on uniform principles (Germany).
- (3) Supervision of the sick on uniform principles (Austria, Czechoslovakia, Germany, Luxemburg) and of the measures necessary for the prevention of sickness (Austria, Esthonia, Latvia, Poland).
- (4) Payment of part of the benefits (Germany, where the federations of funds may undertake the payment of insurance benefits up to half the total, or under certain conditions the total amount for certain groups or cases of sickness).
- (5) Constitution of a joint reserve fund (Great Britain), or grant of financial assistance to funds in difficulties (Poland).
- (6) Establishment and working of hospitals, convalescent homes, etc. (Austria, Czechoslovakia, Esthonia, Germany, Latvia, Luxemburg, Poland).
- (7) Conclusion of agreements with medical practitioners, dentists, pharmacies, hospitals, dealers in curative appliances (Austria, Czechoslovakia, Germany, Latvia, Luxemburg, Poland), and for the supply of medicaments and curative appliances (Austria, Czechoslovakia).
- (8) Appointment of the officials and employees of the funds (Germany, Luxemburg).
- (9) Compilation of statistics (Austria, Czechoslovakia, Esthonia, Latvia, Poland).

METHOD OF ORGANISING FEDERATIONS

Under some laws the object of these groups is considered sufficiently important to make the federation or association of the funds compulsory. In other countries, on the contrary, it is optional for the insurance institutions to affiliate to the federations.

The method of grouping the insurance funds and their affiliation to the federations depend on the type of institutions in the country and the system of affiliation of the insured to the institutions. In countries where the law allows several types of fund (territorial,

occupational, mutual benefit) there is usually a large variety of federations of institutions. Thus in Germany funds of the same type form their own federations for the protection of their special interests. If, however, the law recognises only territorial (or occupational) institutions, the federations of funds are also organised on a territorial (or occupational) basis. In Poland, for instance, where only territorial funds are recognised, there are only regional federations grouped in a national federation.

The fund is usually left free to choose its federation. In Italy (new provinces) and Poland, however, where the establishment of federations is compulsory, the law determines in advance to what group each particular insurance institution must belong.

Compulsory Federations

The establishment of insurance federations is compulsory in Czechoslovakia, Italy (new provinces), and Poland.

In *Czechoslovakia* all funds are bound to belong to a federation of insurance institutions for the purpose of performing general duties. The choice of a federation lies with the managing and supervisory committees of the fund, which decide in a joint meeting by a two-thirds majority of those present as to the federation to which the sickness insurance institution is to belong. In default of this majority the Central Insurance Institution decides (section 93 of the Act of 9 October 1924). The federations are under the supervision of the Central Insurance Institution and in the last resort of the Ministry of Social Welfare (section 93, subsection 3). The Central Insurance Institution may avail itself of the co-operation of the federation in exercising supervision over sickness insurance institutions, especially for the purpose of making inspections (section 93, subsection 4).

The rules may provide that the federated insurance institutions shall grant each other mutual assistance in administering insurance, and may even provide that a federated sickness insurance institution shall pay insurance benefits on behalf of another institution belonging to the same federation (section 93, subsection 9).

In *Italy* (new provinces) federations were set up by the Legislative Decree of 29 November 1925, which prescribed the establishment of two regional federations of sickness funds, one with headquarters at Trento, grouping all the regional funds of Tridentine Venetia, and the other with headquarters at Trieste for the regional funds

of Julian Venetia and the funds of the provinces of Carnaro and Zara. These two federations are incorporated bodies, their rules are approved by the Minister of National Economy, and they are managed by a general meeting, consisting of one representative each of all the federated funds, appointed annually by their administrative councils (section 14).

In *Poland*, too, the federations of funds are compulsory organisations, as each fund is bound to belong to a regional federation, and these in turn combine to form a Central Federation of Sickness Funds. The federations have legal personality. The insurance institutions must contribute to the federation in accordance with a schedule fixed by the Insurance Office. The federations may also receive subsidies from the State and local authorities (section 93 of the Act of 19 May 1920).

On 1 January 1925 the organisation of the Polish regional federations was as shown in the table below:

FEDERATIONS OF FUNDS ON 1 JANUARY 1925 ¹

Date of organisation	Regions covered	Headquarters	Number of funds
July 1922	Cracow and Kielce and the former Austrian part of Silesia	Cracow	31
September 1922	Leopol, Stanislawow, Tarnopol, Volhynia	Leopol	57
February 1923	Poznan and Pomerania	Poznan	58
September 1924	Lodz	Lodz	12
Being organised	City of Warsaw, Warsaw, Lublin and Bialystock	Warsaw	19

¹ MINISTRY OF LABOUR AND SOCIAL ASSISTANCE *Social Insurance in Poland*, p. 80. Report submitted by the Polish Delegation to the Seventh International Labour Conference, Warsaw, 1925.

Voluntary Federations

The establishment of federations is optional in Austria, Esthonia, France (Alsace-Lorraine), Germany, Great Britain, Irish Free State, Latvia, Lithuania, and Luxemburg.

In *Austria* the law provides for the constitution of federations of funds with their headquarters in the territory of the same province (*Bundesland*). Such federations must be formed by the concurrent decisions of the general meetings of the funds concerned. In the case of works funds or mining funds the consent of the heads

of the undertakings is also necessary (section IV, subsection 1 of the Act of 20 November 1917). The federations are placed under the supervision of the State acting through the provincial governor for the headquarters of the federation and in the last resort through the Ministry of Social Administration (section IV, subsection 4). Their rules must be submitted to the supervisory authority for approval (section IV, subsection 7). Employers are entitled to fair representation in the administrative and supervisory bodies of the federation. With a view to ensuring uniform representation of employers, the provincial governor may reserve the right to appoint up to one-quarter of the representatives, the remaining three-quarters being elected by the representatives of employers in the managing committees of the federated funds (section IV, subsection 8).

There are at present in Austria four central federations, which have not been recognised, and in which only regional federations admitted by the law are grouped:

- (1) The Central Commission of Austrian Sickness Funds (*Reichskommission der Krankenkassen Oesterreichs*).
- (2) The Central Federation of Austrian Sickness Funds (*Reichsverband der Krankenkassen Oesterreichs*).
- (3) The Central Commission of German-Austrian Employees' Sickness Funds (*Reichskommission der Angestelltenkrankenkassen in Deutschösterreich*).
- (4) The Central Association of the German Sickness Funds in Austria (*Reichsvereinigung der deutschgeleiteten Krankenkassen in Oesterreichs*).

The law in *Esthonia* (section 269, subsection 1 of the Industrial Code) and *Latvia* (section 34 of the 1922 Sickness Insurance Code) also allows the sickness funds to form federations. The funds have made use of their power in both countries and have set up a Federation of Esthonian Sickness Funds and two Federations of Latvian Sickness Funds.

Similarly the new *Lithuanian* Act provides for the establishment of a federation of district funds which are bodies corporate (sections 166 and 167 of the Act of 9 December 1925).

In *France* (Alsace-Lorraine), where the German Insurance Code of 1911 (amended) is still in force, there are four associations of funds¹:

¹ These groups are not federations of funds as specified in section 406 of the Insurance Code. They are associations for the general purpose of assist-

The Federation of Local Sickness Funds of Alsace-Lorraine.

The Union of Works Funds and Guild Funds in the Departments of Bas-Rhin and Haut-Rhin and the neighbouring districts.

The Lorraine Association of Sickness Funds in Mining and Industrial Undertakings.

The Union of Works Funds and Guild Funds for Mulhouse and the neighbouring district.

The first of these institutions was founded on 26 March 1905. In accordance with its rules its objects are the general assistance of the sick and the protection of the joint interests of the funds. The second was formed in the spring of 1920 and at first included only about 15 funds with a membership of 15,000. Already by 1923 it was a powerful organisation, grouping 93 works funds and four guild funds, representing about 57,500 insured persons. Finally, the Lorraine association includes all the sickness funds for the Lorraine mines and metal works, as well as the funds for various industrial undertakings such as cement works, glassworks, etc. The funds belonging to this association have in certain districts succeeded in playing an important part in social work and the prevention of disease. They work in close co-operation with the hospitals which the industrial funds have set up for their staff.

In *Germany* the sickness funds whose headquarters are situated in the district of the same local insurance office may by the concurrent decisions of their delegate meetings unite to form a federation of funds (section 406, subsection 1 of the Federal Insurance Code). With the consent of the Superior Insurance Office a federation of funds may extend over the districts or parts of the districts of two or more local insurance offices (section 406, subsection 2). Every federation must have rules drawn up by the concurrent decisions of the delegate meetings of the federated funds (section 408). The provisions applying to the relations of sickness funds with medical practitioners, dentists, hospitals and pharmacies apply *mutatis mutandis* to federations of funds (section 410).

The number of the various federations of funds in Germany at the end of 1924 appears from the following table:

ing the sick, which with the consent of the supreme administrative authorities may assume certain functions usually devolving upon federations of funds (sections 414)

FEDERATIONS OF FUNDS AND MEMBERSHIP AT THE END OF 1924

Name of federation	Number of affiliated funds	Membership
Central Federation of German Sickness Funds (<i>Hauptverband deutscher Krankenkassen</i>)	1 580	10,168,617
General Federation of Sickness Funds (<i>Gesamtverband der Krankenkassen</i>)	800	2 500,000
National Federation of German Rural Sickness Funds (<i>Reichsverband deutscher Landeskrankenkassen</i>)	452	2,117,854
Central Federation of Guild Funds (<i>Hauptverband der Innungskrankenkassen</i>)	603	266,394
Federation for the Protection of the Interests of German Works Funds (<i>Verband zur Wahrung der Interessen der deutschen Betriebskrankenkassen</i>)	3,800	3,100,000
Federation of Railway Sickness Funds (<i>Verband der Reichsbahn Betriebskrankenkassen</i>)	28	460,000
Federation of Commercial Substitute Funds (<i>Verband Kaufmännischer Ersatzkassen</i>)	21	748,000

In *Great Britain* associations of approved societies are without the importance, and do not play the part, of the federations of funds provided for in the laws already examined.

The British Act authorises the constitution of associations of approved societies. These are usually intended to pool the sums to the credit of the contingencies funds of the societies in cases where a deficit is discovered which cannot be met out of the contingencies fund of the particular society.

The procedure for obtaining approval for these associations is the same as in the case of societies with branches. The associated societies are then considered as branches of the association, and the joint contingencies fund as the contingencies fund of a society with branches. In no case, however, may the central financial committee exercise powers of control over the administration of any associated society (section 76, subsection 6 of the Act of 7 August 1924).

There are at present 19 associations with an aggregate membership of 151,308, the largest having a membership of 30,337 and the smallest 4,178. The number of societies affiliated to these associations varies between 4 and 34.

In *Luxemburg* the funds, both regional and occupational, may found federations placed under the supervision of the supreme supervisory authority, the central committee. The rules of the federations may not contain provisions contrary to the law or foreign to the purpose of the federation, and they must be submitted to the Government for approval. Any disputes between a federation and the affiliated funds are settled by the central committee (Grand Ducal Decree of 16 October 1926 concerning the establishment of federations of funds in pursuance of section 39 of the Act of 17 December 1925).

CHAPTER III

SUPERVISION

§ 1. — Principles of Organisation

OBJECTS AND METHODS OF SUPERVISION

When the State makes insurance compulsory and requires insured persons and employers to pay contributions, it is its right and duty to supervise the regular working of the insurance system.

In the first place the State must see to it that normal effect is given to the obligation of every person liable to insurance to join an insurance institution, and that the statements and payments prescribed by the law and regulations are made. This supervision, which affects the insured persons and even more the employers, is carried out in particular in the undertakings. Secondly, the authorities must supervise the administrative and financial working of the institutions which are responsible for insuring against the risk of sickness.

Administrative supervision sees to it that the administrative bodies of the insurance funds or institutions are regularly constituted and worked in the conditions defined by the law, regulations, or rules of the institutions. The supervisory authorities make up for any deficiencies on the part of the administrative bodies. If necessary the supervisors may convene these bodies.

Financial supervision involves the examination of accounts, income, expenditure, working capital, reserve funds, the investment of funds, etc. The supervisory authorities watch over the regularly of the actions and the solvency of the institutions. In cases of deficit they must prescribe the methods to be taken — increase of contributions, reduction of benefits, etc.

The law gives the supervisory authorities the necessary powers and means of action for effectively carrying out their work.

In the first place it makes it compulsory for the sickness insurance funds regularly to communicate to the supervisory authorities their general decisions and the results of their financial management at the dates and in the form fixed by the authorities: statistics of insured persons, morbidity statistics, contributions collected,

expenditure on benefits, balance, sheets, etc. Secondly, the supervisory authorities and their agents have the power of investigation. They may examine on the spot all the documents connected with management, and have the right to inspect the establishments set up or used by the funds: dispensaries, hospitals, sanatoria, etc. The supervisory authorities may cancel any irregular decisions, require the funds to correct the mistakes they have observed, and institute judicial proceedings in cases of fund. Sometimes, even, they may impose sanctions (warnings or fines).

This twofold administrative and financial supervision is intended above all to check the lawfulness of the actions taken by the managements of the institutions in virtue of their autonomy under the law. But the competence of the supervisory authorities usually exceeds the limits of supervision properly speaking and includes a right of approval of certain important decisions of the funds, which cannot take effect until such approval has been obtained. This very often applies to the decisions of the funds concerning amendment of the rules, changes in the rates of contribution, the investment of the reserve fund, the introduction of certain additional benefits, the construction or purchase of hospitals, sanatoria, etc.

Moreover, by force of circumstances relations of various kinds are established between the supervisory authorities and the funds which are closer and more frequent than the strict enforcement of the law would require. The supervisory authority is at the same time a centre for advice. It inspires and guides the whole insurance system. It is not merely the protector of the law, but also a technical and social adviser. Without prejudice to the decisions of administrative authorities or the awards of judicial bodies, it acts as a semi-official interpreter and explains the text of the law. When occasion arises it is to this authority that the managers of the funds spontaneously resort for the settlement of the various difficulties they may meet with in carrying out their duties. Thus, by bringing together and using the experience of a number of funds the supervisory authorities can draw attention to actions which have succeeded and those which have failed, and thus help to introduce more homogeneity in management and make the social insurance system more efficient.

NATURE AND CONSTITUTION OF SUPERVISORY BODIES

The general supervision of the working of sickness insurance is normally entrusted to the Ministry which is competent for labour

questions and social welfare (Ministry of Labour, Ministry of Social Welfare, Ministry of National Economy, Ministry of Industry and Commerce, etc.). In countries where there is no such specialised Ministry supervision is within the competence of the Ministry of the Interior (Japan and Lithuania). In Great Britain insurance is under the authority of the Ministry of Health.

The supervision should cover the undertakings and the central and local insurance institutions. It should, therefore, comprise not only central services (division, service, or office) of the competent Ministry, but regional, departmental, and local organs. The nature and constitution of these organs will differ widely according as the State is directly responsible for the management of insurance or its management is entrusted to autonomous institutions.

When the State is responsible for management, insurance is a financially independent public service, and the functions of management and supervision are not always clearly differentiated. The persons responsible for management are officials, and their actions are supervised by other officials of a higher administrative rank who themselves have managerial functions (Bulgaria, Japan: insurance offices). Sometimes financial supervision is entrusted to officials in the financial administrative departments.

When the management of insurance is undertaken by autonomous institutions supervision is in the hands of bodies which are clearly distinct from the sickness insurance funds, and requires the establishment of central services or offices, and local services, offices, or agents.

Central supervision may be attributed either to a ministerial department alone, or to a ministerial department and a national or federal insurance office or council. Regional or local supervision may be attributed either to State officials, or to special regional or local offices, or to both for various fields of insurance.

The State officials usually chosen for this work are labour inspectors or specialised insurance officers or, more rarely, general political authorities (prefects or sub-prefects). The special insurance offices often have employees or agents of their own, to whom they transfer part of their powers for supervision on the spot in the undertakings or local institutions as the case may be.

The various systems of supervision are not necessarily mutually exclusive, and in many countries they are used simultaneously, greater authority being given sometimes to one and sometimes to another.

In order to obtain a general view of the methods adopted in the different countries an attempt has been made to classify the system

of supervision, especially with reference to the essential features of their structure. It is fully realised that this classification is somewhat artificial, but it has been thought useful because it throws light on the general evolution of the legislation of the different countries in the direction of setting up specialised independent supervisory authorities. It has been thought that a distinction could be made between three groups according as supervision is in the hands of a Ministry and State officials, of special (central, regional and local) offices or councils, or of central or local insurance institutions.

✓ Supervision by a Ministry and State Officials

The supervision of the administration of the law and the activities of institutions is entrusted to a Ministry and the regional or local agents of the Government. This system has been adopted in Austria, France (miners' insurance), Great Britain, Greece, Hungary, Italy (new provinces), Irish Free State, Japan, Latvia, and the Serb-Croat-Slovene Kingdom.

Supreme control is exercised by the Ministry of Labour or of Social Welfare in Austria, France (miners' insurance), Hungary, and Latvia, the Ministry of National Economy in Greece and Italy, the Ministry of the Interior in Japan, and the Ministry of Social Policy in the Serb-Croat-Slovene Kingdom. In Great Britain the supervision of the approved societies is entrusted to the Ministry of Health and the Scottish and Welsh Boards of Health, in Northern Ireland to the Ministry of Labour. Further, financial and actuarial supervision is within the competence of two separate ministerial departments, attached to the Treasury. In the Irish Free State supreme control is in the hands of an Insurance Commission subordinate to the Ministry for Local Government and Public Health and of the National Insurance Audit Department.

The central authorities exercise their supervision through the medium of the local public authorities (provincial governors and public authorities of the first instance in Austria, prefects in France for miners' insurance, and in the new provinces in Italy) or of labour or insurance inspectors. In some States the labour inspectors undertake, in addition to their ordinary work, the supervision of the sickness funds (France, mining inspectors; Italy, industrial and labour inspectors; Latvia, labour inspectors); in other States on the contrary there are specialised inspectorates for the supervision of insurance institutions (Hungary, Greece, Great Britain, Irish Free State).

Supervision by Insurance Offices or Councils

In these systems the supervision of the general administration of the law is still in the hands of the Ministry which is competent for social questions, but the actual work of administrative and financial supervision of the institutions is entrusted to independent services, the insurance offices or councils. When special authorities for the supervision of insurance funds are set up, they are not only particularly suited for the effective control of sickness insurance institutions, but also for that of other branches of insurance. Such bodies may also be given many other duties, both administrative and judicial, and thus co-ordinate all the work of the public authorities in the field of insurance.

Offices or councils of this kind have been established in the following countries: Esthonia, France (Alsace-Lorraine and seamen's insurance), Germany, Lithuania¹, Luxemburg, Norway, Portugal, Roumania, and Switzerland. They are usually attached to the Ministry competent for social questions (Ministry of Labour and Social Welfare in Esthonia, Ministry of the Interior in Lithuania, Ministry of Social Affairs in Norway, Ministry of Labour and Social Assistance in Poland, Ministry of Labour, Co-operation and Social Insurance in Roumania, and the Department of National Economy in Switzerland).

Most of these systems of insurance provide for the establishment of a single insurance office or council competent for the supervision of all the institutions in the country (Esthonia, France for seamen's insurance, Lithuania, Luxemburg, Norway, Portugal, Roumania, Switzerland). In some States there are several regional offices subordinate to a central office (France for Alsace-Lorraine, Poland).

The insurance offices may consist solely of public officials (Norway, Poland, Switzerland). In several countries, however, they consist of public officials and representatives of those concerned, namely, insured persons and employers (Esthonia, France for Alsace-Lorraine and seamen's insurance, Germany, Lithuania, Luxemburg, Roumania). These representatives may either be elected by the independent insurance institutions (Esthonia, France, Germany, Lithuania, Luxemburg) or be appointed by the Government authorities (Roumania). This participation by the persons concerned is intended to establish closer contact between the institution

¹ Provision is made in the law for a Superior Social Insurance Office, but it has not yet been set up

supervised and the supervisory authorities; it enables the latter to obtain direct information on the needs of workers and employers, and may thus help to improve the working of the system

Whereas in countries such as France, Germany, Lithuania, and Luxemburg all the functions of supervision are entrusted to the insurance offices and their officials, in others the law to some extent limits the powers of these bodies and entrusts certain functions to other authorities. Thus in Esthonia the administrative and financial supervision of the sickness funds is exercised in the first place by the labour inspectors and workers' insurance authorities, and the Workers' Insurance Council is competent only for the general direction of the work of these institutions. In Norway important supervisory functions are entrusted to the Ministry of Social Affairs and the communal councils. In the Swiss Cantons which have introduced compulsory insurance the supervision of the institutions is in the hands of the Federal Social Insurance Office and the cantonal authorities.

Supervision by Central and Local Insurance Institutions

Instead of the public authorities the independent insurance institutions of various grades may supervise the sickness insurance funds. This system can obviously take effect only where the local insurers are closely connected with a national insurance institution which undertakes insurance against several risks. It has the advantage of allowing reasonable collaboration between sickness insurance and invalidity, old-age, and accident insurance, and thus facilitates the administrative unification of insurance against the different risks.

This method of supervision was adopted in Czechoslovakia by the Act of 9 October 1924. Until that date the supervision of the institutions in this country was in the hands of the administrative authorities of the first and second instance. Since the introduction of the new Act the supervision of the territorial, occupational and mutual benefit funds is exercised by the Central Social Insurance Institution, to which they are subordinate. This Central Institution, which is itself subject to the Ministry of Social Policy, acts as insurer against the risks of invalidity and old age, and is also responsible for the supervision of its local organs, the sickness insurance funds.

The system of administrative and financial supervision adopted under Soviet law may also be placed in this group, although in some respects it is related to the laws in the first group.

In the U.S.S.R. the general direction of social insurance and the supervision of the administration of the law belongs to the Commissariats of Labour of the Union and of the Federal Republics and their local organs, the labour inspectors, and also to the organs of the Commissariat of Finance. The supervision of the work of the local funds on the contrary is exercised by the provincial or regional funds, managed by committees elected by the provincial or regional trade union congresses.

§ 2. — Organisation of Supervision in National Legislation

AUSTRIA

SICKNESS INSURANCE ACT OF 20 NOVEMBER 1922

Since the introduction of the new Act the supervision of sickness insurance institutions is entrusted to the Federal Government and the local administrative authorities. The Ministry of Social Administration is the supreme authority for all State activity in connection with the supervision of the funds. It is assisted by the provincial governors (*Landeshauptmänner*) and the political authorities of first instance in whose district the funds have their headquarters (sections 19, 47, 60).

The powers of these authorities for the supervision of the sickness funds include the following: access to all books, accounts, correspondence and other records of the funds, inspection of the funds, the right to depute a representative to attend all meetings and assemblies of the administrative bodies of the fund, the right to demand that these bodies shall be convened, the right to preside at assemblies or meetings convened on their demand, the right to exercise the functions and fulfil the obligations of the administrative bodies of the fund, either themselves or by means of representatives, at the expense of the fund in cases where the administrative bodies refuse to fulfil their obligations under the law or the rules of the fund, and the right to appoint the members of the managing committee or the delegates if the general meeting or the electors fail to take action (section 19, subsection 4, section 20). These authorities similarly take action in organising sickness insurance when, instead of compulsory medical benefit, an increase in sickness benefit is to be allowed (section 6e, subsection 2), or when an additional contribution is to be imposed on employers whose undertakings do not satisfy the regulations in the matter of hygiene (section 27, subsection 2).

The supervisory authorities may enforce the observance of these regulations by threatening to inflict, inflicting, or enforcing the payment of fines of not more than 120 schillings, and in case of failure to pay the fine, by the detention of members of the managing committee for not more than 14 days (section 19, subsection 3). If the fund fails to carry out the provisions of the law with respect to increases of contributions or reductions of benefits when the resources of the fund are inadequate, the supervisory authority may automatically amend the rules with legally binding effect (section 30, subsection 3). The provincial governor has power in specified cases to order the dissolution of an insurance institution (sections 40, subsection 1; 49, subsection 1; and 57, subsection 1).

For purpose of supervision the Act requires the funds to submit their balance sheets and the results of the audit of the balance sheets annually to the supervisory authorities (section 21, subsection 2). It also requires them to send in returns of their membership, the number of cases of sickness and death, the number of days of sickness, the contributions received and the benefits paid, as well as the amount of the reserve fund and the manner in which it is invested (section 72, subsection 1).

BELGIUM

ROYAL DECREE OF 28 FEBRUARY 1885 AS AMENDED

The Relief and Provident Fund for Seamen Sailing under the Belgian Flag, which is subordinate to the Department of Naval Administration, is managed and supervised by an administrative committee of ten members. This committee has access to the books and all documents connected with the administration of the fund which may be examined by any of its members.

Once a quarter the administrative committee submits to the competent Minister a balance sheet and statement of expenditure on pensions, allowances, etc. The annual accounts of the fund are published in the *Moniteur*.

BULGARIA

SOCIAL INSURANCE ACT OF 6 MARCH 1924

Insurance against the different risks covered by the Act (accidents, sickness, maternity, invalidity, old age) is managed and supervised by the Minister of Commerce, Industry and Labour, who for this purpose set up in the Labour Department a special Insurance Office, its local agents being the labour inspectors.

For purposes of financial supervision there is a special accounts section and an audit committee. The accounts section, consisting of a chief accountant and as many subordinates as the fund has accounts of income and expenditure, is responsible for the supervision of the administration of financial measures (section 183 of the Administrative Regulations of 25 June 1924). The audit committee, consisting of representatives of the Ministry of Commerce, Industry and Labour, the Minister of Finance, the Court of Accounts, the National Bank, and the chambers of commerce and labour, is appointed by the Minister of Commerce, Industry and Labour, and has power immediately upon the expiry of the financial year to audit the accounts of the Social Insurance Fund (section 42).

Reference should also be made to the Superior Labour and Social Insurance Council set up in the Ministry of Commerce, Industry and Labour under section 26 of the Act on Labour Hygiene and Safety, which is intended to act as an advisory body for the administration of the Act of 6 March 1924. This Council consists of:

A. 16 representatives of the State, namely:

- (1) One representative of the Ministry of Commerce, Industry and Labour.
- (2) One representative of the Ministry of Finance: the head of the Estimates and Accounts Department.
- (3) The head of the Labour Department.
- (4) The head of the Department of Commerce and Industry.
- (5) The head of the Department of Mines, Quarries and Mineral Springs.
- (6) The head of the Department of Agriculture in the Ministry of Agriculture and State Domains.
- (7) The head of the Social Welfare Department in the Ministry of the Interior and Public Health.
- (8) The Director-General of Statistics.
- (9) The Director of Public Health.
- (10) The Director of Railways.
- (11) An architect.
- (12) A constructional engineer
- (13) A mechanical engineer.
- (14) An actuary.
- (15) A secretary of a chamber of commerce.
- (16) A member of the Codification Commission of the Ministry of Justice.

B. 8 representatives of employers, representing the following branches: industry, mining, commerce, handicrafts, and agriculture.

C. 8 representatives of workers, representing the following branches: industry, mining, commerce, handicrafts, agriculture, and State employees.

D 8 persons well known on account of their work in connection with social legislation, including one professor of political economy or sociology, one professor of chemical technology, and two Members of Parliament

E 2 representatives of the medical profession (section 48, subsection 1).

This Council is convened by the Minister of Commerce Industry and Labour once a year, and also for special meetings when the Minister considers necessary or when at least half the members demand that the Council be convened (section 48, subsection 5)

All draft orders and regulations for the administration of social legislation must previously be examined by the Council (section 48, subsection 6).

The Council elects from its own members a standing committee of five persons which may be convened in an advisory capacity whenever the Labour Department considers this necessary (section 48, subsection 7)

CHILE

ACT OF 8 SEPTEMBER 1924

The general administrative supervision of the enforcement of the Act and the actuarial supervision of insurance institutions are undertaken by the Central Social Insurance Council.

CZECHOSLOVAKIA

GENERAL SYSTEM (ACT OF 9 OCTOBER 1924 ON INSURANCE OF WORKERS AGAINST SICKNESS, INVALIDITY, AND OLD AGE)

The chief feature of the system of supervision established by the new Czechoslovak Act is that all the functions of supervision of the sickness insurance funds are entrusted to an independent institution responsible for insurance against the risks of invalidity and old age, the Central Social Insurance Institution. The administrative authorities of first and second instance hitherto responsible for supervision of the funds no longer have any functions in connection with sickness insurance.

The Central Social Insurance Institution is in turn subject to the supervision of the Minister of Social Welfare, who must submit to the National Assembly a report on the position of sickness insurance prepared once a year by the Institution

The Central Institution, whose headquarters are at Prague, has the following administrative bodies a committee, a managing committee, and a directorate (section 76).

The committee consists of a president and forty members. The president is appointed by the President of the Republic for a term of four years. Of the 40 members, 12 belong to the insured persons' group, 12 to the employers' group, and 16 to the experts' group. The members belonging to the first group are elected by the members of the managing committees of the sickness insurance institutions who represent the insured persons; the persons belonging to the second group are elected by the members of these committees who represent the employers. The remaining 16 members are appointed by the Government from among social insurance experts, half being employers and half workers (sections 77-79).

The managing committee consists of the president of the institution and ten members, three of whom belong to the insured persons' group, three to the employers' group, and four to the experts' group (section 81, subsection 1).

The executive organ of the Central Institution is a directorate of three persons, who are appointed and dismissed by the committee subject to the consent of the Minister of Social Welfare (section 82, subsection 1).

Every sickness insurance institution is bound to submit to the Central Institution annually a balance sheet, the auditors' report on the balance sheet, and a statement of the variations in membership, the incidence of sickness and mortality, the number of days' sickness, the insurance contributions and benefits, and the amount and investment of the reserve fund (section 87). The Central Institution may at any time require the funds to submit the books, documents, lists, and papers to the officials appointed by it, and to give any

information necessary for the exercise of supervision (section 86, subsection 1).

Further, it may require that meetings of the administrative bodies of the sickness insurance institutions be convened, and may convene them itself if its requirement is not satisfied. It may appoint a representative to preside at these meetings.

If an administrative body of a fund refuses to perform its duties, the Central Institution may have them performed through its representative at the expense of the fund. Similarly, if the electors refuse to elect the members of the administrative bodies of the fund or a court, the institution appoints such members, except in the case of delegates to the general meeting (section 86, subsections 2-4).

The Central Institution also has the right to dissolve the managing committee or supervisory committee of a sickness fund if it repeatedly fails in its resolutions to observe the provisions of the Act, orders, or rules, or if its administration manifestly prejudices the interests and working of the fund. An appeal against the decision of the Central Institution may be taken to the Ministry of Social Welfare (section 88).

In addition to the general provisions on the exercise of supervision, the Act contains several detailed provisions on the intervention of the supervisory authorities in the administration of sickness insurance. Thus the Central Institution has the right to propose changes in wage classes (section 12, subsection 7), to lay down principles for the remuneration of the responsible officials of the funds (section 56), to take the necessary measures when the managing committee of a fund fails to pay attention to the strictures of the supervisory committee (section 66, subsection 3), to appoint the managers of the insurance institutions and to take the necessary measures when these officials report to it that the decisions of the general meeting or managing committee are contrary to the provisions in force (sections 69 and 70), to veto amendments to the rules within sixty days of the date on which the fund notifies the decision for amendment (section 71, subsection 2), to wind up a sickness insurance institution in order to amalgamate it with another institution (section 72, subsection 1), and to decide on the winding up of insurance institutions on the request of the managing committee and supervisory committee or of the employer (section 73).

MINERS' INSURANCE (ACT OF 11 JULY 1922)

The district benefit societies are under the supervision of the Mining Inspectorate, which is subordinate to the Ministry of Public Works. This supervision refers mainly to the strict observance of the provisions of the law and the rules, and to the necessary conditions for the societies to be able permanently to fulfil their obligations. In particular, the mining inspectors must see to it that the capital of the society is invested in accordance with the regulations, that in general its financial operations are in accordance with existing regulations, and that the financial position of the society is fully and clearly set forth in the final accounts and the balance sheet (section 68, subsections 1-3).

For this purpose every society must submit to the inspectorate during the quarter following the end of the calendar year an annual report, the final accounts, a statement on the property and its investments, and a statistical report (section 72, subsection 2). The inspectors have the power to inspect all books, accounts, correspondence, and other documents, to demand their submission, to check the cash accounts and to attend all meetings and sessions of the administrative bodies of the society. The representative of the inspectorate must suspend all decisions contrary to the law or the rules. A decision of one of the administrative bodies may further be suspended within a fortnight of receipt of the minutes of the session at which the decision was taken. An appeal against the notice of suspension issued by the mining inspectors may be lodged with the Ministry of Public Works within a fortnight of its receipt (section 69).

The mining inspectors also have the power to demand that meetings and sessions of the administrative bodies of the funds be convened, to convene them themselves, and to preside over such meetings. If the administrative bodies of a society cannot be formed, or are unable to carry out their duties, the super-

visory authorities may, themselves or through the medium of their representatives, undertake the functions of these bodies. They also have power, in special circumstances render it impossible to administer a society in accordance with the rules, to take over its administration (section 70-71).

The compliance of the managing committee of the society with the instructions issued by the supervisory authorities may be secured by the threat and imposition of penalties. In the event of repeated failure to comply with these instructions, the inspectors may dissolve the managing committee (section 68, subsections 4 and 5)

ESTHONIA

SICKNESS INSURANCE ACT OF 23 JUNE (6 JULY) 1912 AND ACT OF 11 MAY 1920

General administrative supervision of the enforcement of the law and technical supervision of the insurance institutions are in the hands of the Workers' Insurance Council and the Labour Protection and Social Insurance Department of the Ministry of Labour and Social Welfare, the workers' insurance authorities and the labour inspectors.

Workers' Insurance Council

The Workers' Insurance Council, set up in accordance with the Act of 11 May 1920, under the chairmanship of the Minister of Labour and Social Welfare or his representative, consists of the chief and deputy chief of the Labour Protection and Social Insurance Department, four persons representing respectively the Ministries of Commerce and Industry, of Agriculture, of Finance, and of Justice, one representative of the Superior Health Office, five representatives of persons liable to insurance, and two representatives of employers.

The five workers' representatives and their substitutes are elected by a meeting of the delegates of all insurance funds, and the two employers' representatives and their substitutes by the accident insurance associations.

The Council is responsible for supervising the administration of social insurance legislation, and issues the necessary instructions and circulars for the interpretation of such legislation. With respect to sickness insurance institutions, in particular, the Council has competence:

- (1) To fix rules for the book-keeping and presentation of accounts of the funds.
- (2) To issue regulations for supervising the work of the funds.
- (3) To review, modify or cancel the decisions of the workers' insurance authorities.

A plenary session of the Council may appoint permanent or special committees, whose duty it is to supervise the insurance institutions, including the sickness funds.

An appeal against the decisions of the Council or its committees may be taken to the Supreme Court.

Labour Protection and Social Insurance Department in the Ministry of Labour and Social Welfare

This Department acts as a secretariat for the Workers' Insurance Council. Its functions include those of drafting legislation on social insurance, directing the work of labour inspectors with respect to insurance, supervising the insurance institutions, answering the questions addressed to these institutions in so far as they do not involve decisions on points of principle, which are within the competence of the Workers' Insurance Council

Workers' Insurance Authorities

The workers' insurance authorities, established in accordance with the Act of 11 May 1920, are eight in number, one and the same authority acting for the two districts of the capital, Tallinn (Reval).

The chairman is the justice of the peace, and the authority consists of the district labour inspector, a representative of the municipal administrative authorities, two workers' representatives, and two employers' representatives.

The employers' representatives are elected in accordance with the Elections Order of 23 August 1920 by a meeting of the owners of the undertakings whose workers belong to the funds in the district of the insurance authority. The

election of the workers' representatives takes place in a meeting of delegates, appointed by the managing committees of the sickness funds in the district from among members of the committees and in proportion to the membership of the funds.

It is the duty of the workers' insurance authorities to administer social insurance laws and the orders and decisions of the Workers' Insurance Council, and to take decisions on the complaints made against the orders of the labour inspectors.

They have power to review the financial situation of the sickness funds, their administration, book-keeping, and the accounts submitted on behalf of the management, as also the reports of the labour inspector on the results of his inspections. They supervise the work of the general meeting and the managing committee, and have the right to dismiss members of the managing committee and institute penal proceedings against them.

The chairman of the workers' insurance authority has the right to veto its decisions. If he makes use of this right the matter is referred to the Ministry of Labour and Social Welfare, which may either confirm the decision of the authority or submit it to the Workers' Insurance Council. An appeal against the decisions of the workers' insurance authority may be taken to the Workers' Insurance Council.

Labour Inspectors

Estonia is divided into five inspection districts with a labour inspector (inspection commissioner) at the head of each. The five inspectors and their five assistants are subordinate to a chief inspector, who is directly attached to the Department of Labour Protection and Social Insurance. Their functions are defined by the Order of 19 December 1918 and the provisions of the Industrial Labour Code.

The inspectors have power on the decisions of the insurance authority, or when they consider it expedient, to audit the accounts of the fund, and supervise its management and book-keeping and the financial reports of the managing committee (section 362 of the Industrial Labour Code).

If need be, the inspectors may temporarily relieve the members of the managing committee of their functions if proceedings have been taken against them for one of the criminal actions specified in section 359 1, or for an action involving dismissal (section 354 of the Code).

FRANCE

Alsace-Lorraine

SOCIAL INSURANCE CODE OF 19 JULY 1911

Supervision is entrusted to the General Social Insurance Office for Alsace and Lorraine which is directly subordinate to the Government (General Directorate for Alsace-Lorraine), the four superior social insurance offices (the superior insurance offices for Strasbourg, Metz and Mulhouse, and the superior railway insurance office for Alsace-Lorraine), and the 27 insurance offices, of which 5 are municipal offices situated in the towns of Strasbourg, Metz, Mulhouse, Colmar and Guebwiller; the remaining 22 offices have their headquarters in the chief towns of each district of the departments of Haut-Rhin, Bas-Rhin, and Moselle.

The district insurance offices are presided over by sub-prefects, and the municipal offices by the mayors; their organisations and functions are the same as under the German system.

Miners' Insurance

ACT OF 29 JUNE 1894

The local authorities for supervising the mining benefit funds are the mining inspectors and the prefectural authorities. The central supervisory authority is the Ministry of Labour.

In accordance with the Ministerial Circular of 16 March 1896, the inspectors must themselves inspect each benefit fund at least once a year. They must countersign the registers they inspect, stating the date. A report must be

¹ Persons sentenced by a court to penalties involving the loss or limitation of their civil rights, or their dismissal; persons who have been sentenced by a court for theft, fraud, usurpation of rights, squandering of property, receiving of stolen goods, etc.

drawn up on each inspection stating the observations and checks made by the inspector, together with remarks on questions of general interest such as any changes in the rates of contribution and benefits which may have been decided by the administrative council.

Benefit funds must submit their books, reports, and accounts of all kinds to the prefect and the mining inspector. Once a year the funds must send to the Ministry of Labour, through the medium of the prefect, a report in the form prescribed by the Minister showing their financial position and the number of cases of sickness or death among their members during the year (section 15).

Seamen's Insurance

ACT OF 29 DECEMBER 1905

The financial supervision of the only insurance institution, the French Seamen's Provident Fund, is within the competence of the Superior Council of the Seamen's Disablement Fund (section 17). This Council consists of two members of the Senate, two members of the Chamber of Deputies, one Councillor of State, one Councillor of the Court of Accounts, one naval officer representing the Minister of the Marine, six representatives of shipping appointed by the National Organisation of French Shipowners, six representatives of members of the Disablement Fund appointed by the occupational organisations concerned. The members of the Council are appointed for a term of three years and are re-eligible.

The annual accounts are submitted to the Council for preliminary examination, it ascertains that they are in agreement with the records kept as a check by the Administrative Council and Treasurer of the Seamen's Disablement Fund. The Council has the power to require the administration of the Disablement Fund to supply any information it considers necessary.

The Council makes a report on the position of the Disablement Fund which is submitted to the President of the Republic and appended to the accounts presented to Parliament in accordance with section 22 of the Finance Act of 15 May 1818 (Decree of 8 March 1887, sections 2, 4, 7, 9, and 11).

GERMANY

GENERAL INSURANCE (FEDERAL INSURANCE CODE, TEXT OF 15 DECEMBER 1924)

The supervision of sickness, accident, and invalidity insurance institutions is entrusted to special supervisory authorities (*Aufsichtsbehörden*), of which there are three grades:

- (a) The Federal Insurance Office (*Reichsversicherungsamt*)
- (b) The superior insurance offices (*Oberversicherungsämter*).
- (c) Local insurance offices (*Versicherungsämter*).

The local insurance offices are responsible for supervising the sickness funds.

The supervisory authorities must comply with the regulations laid down by the Federal Minister of Labour and the general instructions of the supreme Federal and State administrative authorities. The following provisions apply to all supervisory authorities and refer to the supervision of invalidity and accident insurance institutions as well as sickness funds.

The object of supervision is to ensure that the law and rules are observed as the purpose of the insurance system requires (*wie es der Zweck der Versicherung erfordert*) (section 30, subsection 1).

Any supervisory authority may at any time examine the administration and accounts of the insurance institutions (section 31, subsection 1). It also has the right to demand that meetings of the administrative bodies be convened, and if this demand is not complied with it may convene them itself and direct the proceedings (section 32). Without prejudice to the rights of third parties and unless otherwise provided by law, it decides any disputes concerning the rights and duties of the administrative bodies and their members, the inter-

pretation of the rules and the validity of elections (section 33). With a view to securing respect for the law and the rules it may impose fines on the members of the administrative bodies of the institutions, their agents, officials and salaried employees (section 31, subsection 3).

The members of the administrative bodies of the institutions and their agents, officials, and salaried employees must produce to the supervisory authority or its representatives on demand all books, accounts, vouchers, and records as well as documents, securities, and assets in their custody, and give all information required for the purpose of the exercise of the right of supervision (section 31, subsection 2). The supervisory authority may require representatives of the employers and insured persons to take part in its inspections (section 34, subsection 2).

The composition and powers of the various offices are as follows

Federal Insurance Office

The Federal Insurance Office, whose headquarters are in Berlin, acts as the supreme supervisory authority. It consists of permanent and temporary members. The permanent members and the president are appointed for life by the President of the Republic on the recommendation of the Federal Council (sections 85 and 86). There are 32 temporary members, of whom eight are appointed by the Federal Council including at least six from among its own members, 12 are elected as representatives of employers and 12 as representatives of insured persons (section 87, subsection 1).

The Federal Insurance Office administers insurance as the supreme judicial, administrative, and supervisory authority (section 83). With respect to sickness insurance, it has no organising functions. It authorises the establishment of substitute funds whose district extends beyond the boundaries of a Federal State (section 514, subsection 1).

A State insurance office which was established before the Act came into force may remain in existence so long as there are at least four superior insurance offices under its jurisdiction. It takes the place of the Federal Insurance Office for this territory (section 105). There are such State insurance offices at Munich, Dresden, and Karlsruhe.

Superior Insurance Offices

A superior insurance office is established as a rule for the district of each superior administrative authority (section 62). In the case of a joint office for several States, the consent of the State Governments concerned is necessary (section 65).

The superior insurance office consists of members chosen from among public officials, and of assessors (section 68). In addition to the director, each office appoints at least one other member for life who acts as deputy-director. Half the assessors are elected from among employers and half from among insured persons. The total number of assessors is 40, but it may be increased or reduced by the supreme administrative authority (section 71).

The superior insurance offices administer insurance as superior judicial, administrative, and supervisory authorities (section 61). They have competence to approve the rules and their amendment (sections 324, 408, subsection 1, 326 and 428), and most of the optional provisions of the rules (sections 176, subsection 3; 180, subsection 3; 191, subsection 2; 193, subsection 1; 195b, subsection 2, etc.).

If the provision of medical attendance in connection with the sickness fund is seriously imperilled by the fact that the fund cannot conclude a contract on suitable terms with medical practitioners, the superior insurance office may give the fund power to grant cash benefit not exceeding two-thirds of the average amount of the statutory sickness benefit, instead of medical attendance or other requisite medical treatment (section 370, subsection 1).

Local Insurance Offices

Local insurance offices, which are responsible for the actual supervision of the sickness funds, are set up as a rule in connection with every subordinate

administrative authority (section 36, subsection 1). The director of the subordinate administrative authority is *ex officio* president of the office. At least one permanent vice-president is appointed (section 39, subsection 1). In the cases specified in the Act, representatives of the insured and employers in equal numbers are called in as assessors (section 40). The representatives, of whom there must not be less than 12, are elected by the members of the managing committees of funds with a membership of at least 50 (sections 41 and 42).

The principal function of these offices is to supervise the sickness funds and federations of funds (sections 377, subsection 1, and 413), to approve the rules for sick persons (sections 347, subsection 2; 507, subsection 2) and to co-operate in the supervision of the sick (section 347, subsection 4).

So long as the persons entitled to vote refuse to elect the administrative bodies of a fund, the insurance office appoints the members or substitutes. So long as the managing committee, its president, or the delegate meeting refuse to perform their duties, the office, either directly or through an agent, performs those duties (section 379).

The insurance office may temporarily order an increase in contributions or a reduction in benefits to an amount not less than the regular benefits if the financial situation of the fund so requires (section 391, subsection 1).

It has the right to dismiss the members of the administrative bodies of a fund or federation of funds (sections 24 and 408, subsection 2).

MINERS' INSURANCE (ACT OF 1 JULY 1926)

The Federal Mining Benefit Society, the district mining funds, and the special sickness funds are subject to supervision by the Federal Minister of Labour. The Minister of Labour entrusts the supervision of the district mining funds and the special funds to the competent State authorities. If the area of any one of these funds covers the territory of more than one State, it is subject to supervision by the authorities for the State in which its headquarters are situated (section 151).

GREAT BRITAIN AND NORTHERN IRELAND

ACT OF 7 AUGUST 1924

The supervision of sickness insurance institutions is undertaken by various central departments, each of which is competent to supervise a specified aspect of the business of approved societies. Some of these authorities supervise all the insurance institutions in the country, whereas others cover only part of the territory of the State. These authorities are the following:

For general administrative supervision, the Ministry of Health, the Welsh Board of Health, the Scottish Board of Health, and the Ministry of Labour for Northern Ireland.

For financial supervision, the National Insurance Audit Department.

For actuarial supervision, the Government Actuary's Department.

Moreover, the Ministry of Health Act of 1919 set up advisory boards, known as "consultative councils", for England, Wales, and Scotland which must co-operate with the central departments.

Uniformity in the work of the authorities for the different parts of the country is secured by the National Health Insurance Joint Committee, consisting of the Minister of Health, the Secretary for Scotland, a person appointed by the Minister being a person having special knowledge and experience of national health insurance in Wales, and the Minister of Labour for Northern Ireland (section 88, subsection 1).

Administrative Supervision

The authority for the general supervision of the administration of the Act and for administrative control is the Minister of Health, whose powers as

regards Wales are exercised through the Welsh Board of Health. Scotland and Northern Ireland have administrative supervisory authorities independent of the Ministry of Health (the Scottish Board of Health and the Ministry of Labour for Northern Ireland).

The local supervisory authorities are the special inspectors appointed by the Minister for the purposes of the Act, and the regional medical staff of the Ministry.

There are in England 12 inspection divisions, each of which is divided into districts. Scotland and Wales are divided into districts. The English inspection service has a staff of 526 persons.

The inspectors have power to enter at all reasonable times any premises or place, other than a private dwelling house not being a workshop, where they have reasonable grounds for supposing that persons liable to insurance are employed. They may make such examination and enquiry as may be necessary for ascertaining whether the provisions of the Act are actually observed (section 92, subsection 1). Irregularities are often dealt with at the actual time of inspection or by correspondence. Otherwise measures are taken after due warning¹.

The Regional Medical Service was set up to give advice to approved societies and doctors in cases of incapacity for work in which it appears that a second medical examination may help to restore working capacity. Although the functions of this Service are purely advisory, it has certain supervisory powers, for instance those of examining the sickness reports of medical practitioners and checking the excessive prescription of drugs. Regional Dental Offices have also recently been appointed.

In England and Wales this Service is in the hands of medical practitioners, each of whom is competent for a specified area, there being 30 in England and three in Wales (sub-divided into five divisions with a divisional medical officer at the head of each). In Scotland there are six district medical officers².

There is no Regional Medical Service for Northern Ireland.

Financial Supervision

The accounts of each approved society, and branch of a society, and each insurance committee must be submitted to the supervision of auditors appointed by the National Insurance Audit Department. These officials are responsible for examining all payments under the head of cash benefit and administrative expenditure. Any irregular expenditure on administration on the part of a representative of an approved society or insurance committee is notified to the central department, which gets into touch with the society or committee in question with a view to having the sum refunded or obtaining a promise that the offence will not be repeated. The National Insurance Audit Department has a central office and 44 local offices in England, Wales, and Scotland, grouped in five divisions with an inspector at the head of each³.

GREECE

ROYAL DECREE OF 8 DECEMBER 1923 AMENDING THE PROVISIONS OF ACT No. 2868 AND THE DECREE OF 19 NOVEMBER 1923

The constitution and working of all workers' insurance institutions are subject to State supervision exercised by the Ministry of National Economy, assisted by a special audit committee and the social welfare inspectors.

The audit committee, which consists of two insured persons and one official, is appointed every two years by the Ministry of National Economy. The accounts it examines are submitted to the Minister together with a report drawn up by the committee (section 7).

The social welfare inspectorate, which is subordinate to the Ministry of National Economy (Labour and Social Welfare Department), supervises the administration of social welfare legislation and inspects the pensions funds,

¹ ROYAL COMMISSION ON NATIONAL HEALTH INSURANCE: *Evidence*, Appendix, Part 1, p. 12.

² *Ibid.*, pp. 97 and 191.

³ *Ibid.*, Appendix, Part IV, No. CI.

mutual relief and benefit funds, and unemployment funds. It consists of one first or second class inspector and two first or second class assistant inspectors (section 11, subsection 2)

HUNGARY

ACT No XIX OF 1907

Under the Hungarian law there is a twofold supervision of sickness insurance institutions. The district, works, and mutual benefit funds are in principle subject to supervision by the National Workers' Insurance Fund and the National Office attached to the Ministry of Social Welfare and Labour. Since 1919, however, these two institutions have ceased to exist. The independence of the National Fund was abolished by Order No 104,065 of 6 September 1919, and a Ministerial Council was instructed to manage this institution. In addition, the functions of the National Workers' Insurance Fund at Budapest were transferred in March 1919 to the Ministry of Social Welfare and Labour, and the Fund has not been restarted. Thus, supervision of the sickness funds is solely in the hands of this Ministry, which carries out this work through the medium of special insurance inspectors.

Through these inspectors the Ministry makes a thorough examination on the spot, at least once a year, into the activities, financial administration, books, records, correspondence, and documents of the insurance funds (section 173, subsection 1). It may further require the funds without warning to supply a statement of their accounts, and at any time request them to give information on their activities, changes in membership and in the number of sick persons, and their financial situation. Thus, in a general way, it sees to it that the insurance institutions observe the provisions of the law and the rules, fulfil their obligations under the law, are reasonably economical in their expenditure on administration, and employ their income exclusively for the object specified in the law (section 173, subsection 2).

The Ministry may at any time order that the administrative bodies of the institutions shall be convened, or if need be convene them itself, and through its delegates take part in their meetings and discussions and even preside over the meetings by its own officials (section 173, subsection 3).

If the administrative bodies of a fund are constituted contrary to the law or regulations, and if their conduct is contrary to the law or regulations or prejudicial to the interests of insurance, or finally if their activities are not directed towards the ends assigned to insurance, the Ministry may dissolve these bodies, order new elections, and forbid for sufficient reasons the re-election of the members of the dissolved administrative bodies, and administer the fund through its own representatives at the expense of the offending administrative bodies, or of the fund (section 173, subsection 4).

If the members of a fund or the employers refuse to elect the general meeting of the fund, or if the delegates to the general meeting do not elect the members of the managing committee, the supervisory committee, or the arbitration court, the Ministry may temporarily fill the vacancies in these administrative bodies until the elections prescribed by the law or the rules have been held (section 174).

Finally, the Ministry has the right on its own initiative to set aside any decision or order of the administrative bodies of the fund which is contrary to the provisions of the law or instructions or regulations in force, or to the aims and objects of the fund (section 175, subsection 1).

The Ministry must keep an up-to-date record of the insurance funds, compile their statistics, supervise and control the activities of these institutions, and settle all disputes connected with insurance (section 172).

With a view to ensuring the administration of the law and instructions, the Ministry and the inspectors may impose fines on the administrative bodies and the funds or the responsible persons, as the case may be (section 173, subsection 2). If there is evidence of a crime or misdemeanour in the administration of the funds, the Ministry must immediately notify the proper court (section 176, subsection 1).

IRISH FREE STATE

NATIONAL INSURANCE ACT OF 16 DECEMBER 1911 AS AMENDED

The sickness insurance institutions are subject to supervision by three separate authorities, one being competent to supervise the enforcement of the Act and for administrative control and the other two for auditing and actuarial supervision.

The administrative supervision of the sickness insurance system is in the hands of the Insurance Commission, consisting of a president and two commissioners, one of whom must be a medical practitioner. It works under the supervision of the Minister of Local Government and Public Health and acts through the factory inspectors, who are subordinate to the Chief Factory Inspector at Dublin.

A special advisory committee is attached to the Commission which consists of representatives of employers and approved societies, medical practitioners, and other persons appointed by the Insurance Commissioners; at least two members of the committee must be women.

The financial supervision of the approved societies is within the competence of the National Insurance Audit Department, attached to the Ministry for Finance. This Ministry also appoints a Valuer, responsible for the actuarial supervision of the institutions.

The functions of these authorities are similar to those of the corresponding authorities in Great Britain¹.

ITALY (New Provinces)

ROYAL LEGISLATIVE DECREE OF 29 NOVEMBER 1925, No. 2146, AND ADMINISTRATIVE REGULATIONS OF 4 MARCH 1926, No. 528

The sickness funds are subject to the supervision of the Minister of National Economy, who acts through the prefects of the provinces and the industrial and labour inspectors (section 15, subsection 1).

Under the law the funds and federations of funds must submit once a year, in June, their balance sheets for the previous year to the Minister of National Economy (section 16).

The Minister has the right to be represented by a delegate at the meetings of the administrative council of the sickness funds and federations of funds (section 15, subsection 2).

If a fund is not organised in accordance with the law, or continues its irregular activities in spite of a warning, the Minister of National Economy may dissolve its administrative council and appoint a Government commissioner instead (section 13 of the Administrative Regulations).

JAPAN

HEALTH INSURANCE ACT OF 22 APRIL 1922

The general supervision of the enforcement of the law and the working of the sickness insurance funds is in the hands of the Minister for Home Affairs and the Health Insurance Division of the Social Affairs Office, which is attached to the Ministry for Home Affairs.

Minister for Home Affairs

The Minister for Home Affairs has competence to approve the constitution of funds (section 29) and the amendment of their rules (section 26). He may require any fund to make reports, inspect the state of its business and property, or take any other action necessary for supervision (section 37). The Minister fixes the rate of contribution and makes the financial estimates for the first year of working of the fund (section 14 of the Administrative Regulations).

¹ See pp. 671-672.

If the administrative bodies of the fund have not been appointed, or there is some other hindrance to their action, or if a member of these bodies neglects his duties, the Minister may appoint an official to administer the fund (section 38, subsection 1). If the administration of the fund is considered contrary to the law or the interests of insured persons, the Minister has the right to annul the resolutions of the administrative bodies of the fund, discharge members of the managing committee, or order the dissolution of the fund (section 29)

Social Affairs Office

This Office has a Health Insurance Division for managing the insurance offices to which persons liable to insurance must belong if they do not join a works fund. It has three services (medical service, supervisory service, accounts service), and the Osaka office, which covers the Western part of Japan.

The Insurance Division has power to give instructions to a fund if the general meeting has failed to reach a decision (section 39 of the Administrative Regulations). It approves the annual financial estimates, except for the first year (section 35 of the Regulations), and all changes in the rates of contributions (section 49 of the Regulations), the administration of the reserve fund (section 51 of the Regulations), loans (sections 53 and 54 of the Regulations), and any transfer of the property of the fund (section 55 of the Regulations).

LATVIA

SICKNESS INSURANCE CODE OF 1922

The sickness insurance funds are subject to the supervision of the Ministry of Social Welfare and the labour inspectors.

Ministry of Social Welfare

This Ministry intervenes in the management of those independent insurance institutions which fail to comply with the provisions of the law and the rules. Thus if the managing committee fails to convene the general meeting to decide whether contributions are to be increased or benefits reduced, in order to place the finances of the fund on a sound footing, this meeting must be convened by order of the Ministry of Social Welfare (sections 73 and 74). Similarly, if the general meeting fails to reduce benefits or increase contributions even above the statutory maximum if the moneys of the fund are inadequate to cover the expenses for cash benefit at the minimum rates, the Ministry takes the necessary measures for this purpose, and the managing committee of the fund must carry out its instructions (sections 73, 75, and 76).

If the general meeting or managing committee of the fund contravenes the provisions of the law or the rules, the Ministry of Social Welfare orders the managing committee to correct the irregularity within a specified period. The members of the committee who are guilty of contravention may be removed from office, and legal proceedings may be instituted against them (sections 100 and 101).

Labour Inspectors

Labour inspection officials may undertake an enquiry into the moneys of an insurance institution, its activities, its accounting, and the submission of accounts by the administrative bodies. They have the right to demand a statement of accounts and information on the members of the fund sickness, mortality, contributions, subsidies received, and the medical assistance and cash benefits granted. The report on any enquiry undertaken by a labour inspector must be submitted to the Ministry of Social Welfare for examination (sections 98 and 99).

LITHUANIA

SICKNESS INSURANCE ACT OF 9 DECEMBER 1925 AND ACT OF 23 MARCH 1926 ON THE SUPERIOR SOCIAL INSURANCE FUND

With a view to supervising the new sickness insurance system the law provides for the establishment of a Superior Social Insurance Office attached to

the Ministry of the Interior. This Office is to consist of two representatives of the Ministry of the Interior, two representatives of insured persons, and one representative of employers the latter three members being elected or a term of three years.

During the session of the Seimas of 9 July 1926, an amendment passed its third reading according to which the Minister of the Interior may appoint only one representative, the other being appointed by organisations of the medical profession.

In the *Memel Territory*, the supervision of the Insurance Office is exercised by the Directorate (section 179 of the Insurance Office rules of 30 December 1922).

LUXEMBURG

ACT OF 17 DECEMBER 1925 AND ADMINISTRATIVE REGULATIONS OF 26 MARCH 1926

The sickness funds are supervised under Government control by a Central Committee, consisting of.

- (a) A president, an employer, and a worker, appointed by the Director-General for Social Welfare.
- (b) Two representatives elected by employers.
- (c) Four representatives elected by insured persons.

The Committee is assisted in its work by salaried employees, appointed and paid by the Government, and placed under the direction of the president of the Committee. The Government may grant these employees the status of officials (section 68). According to the Administrative Regulations the Government will recover from the various types of funds, in proportion to their membership, the salaries paid to, and all other expenses incurred in respect of, the officials of the Central Committee (section 68 of the Act and section 6 of the Regulations).

In view of the small size of the country, no provision has been made for local supervisory authorities.

It is the duty of the Central Committee to watch over the observance of the provisions of the law and the rules. It has the right to obtain information on and check all the activities, books and accounts of the funds. Every sickness fund must submit to the Central Committee in the prescribed form and within the prescribed time limit reports on its members, cases of sickness and death, contributions collected, benefits granted, sums paid to medical practitioners and pharmacists, together with a statement of account (section 65).

The Committee must investigate cases of overlapping insurance, and must carry out the duties assigned to it when it learns that a representative is ineligible or that he has been guilty of serious neglect of his duties (sections 11 and 59 of the Act and section 3 of the Regulations).

The Committee may order that the administrative bodies of a fund shall be convened or, if this order is not complied with, may itself convene the meeting. It may appoint persons to conduct the proceedings of the meeting it has ordered. Further, if the managing committee of a fund has not been appointed or cannot carry out its duties at the general meeting, it may replace this committee and choose the president of the meeting (sections 51, subsection 2, and 52, subsection 4). Similarly, if the insured persons or their employers refuse to elect representatives to the general meeting, the Central Committee must itself provide for the appointment of such representatives (section 51). Finally, if two successive votes in the managing committee of a regional fund are without result, the choice of a president is entrusted to the Central Committee (section 50, subsection 2).

The Central Committee may enforce the observance of the provisions of the law and the rules by the members of the administrative bodies of the fund by disciplinary penalties (warnings, reprimands, or, if need be, fines).

NORWAY**SICKNESS INSURANCE ACT OF 6 AUGUST 1915**

Supervision of sickness funds is within the competence of the State Insurance Institution attached to the Ministry of Social Affairs, which has the right under the law to issue detailed instructions concerning the administration of sickness insurance. Local supervision is in the hands of communal councils.

Ministry of Social Affairs

The Ministry intervenes in the administration of the funds in all cases where the Act prescribes that a decision is to be taken by the Crown or "the competent Ministry." It decides, on the recommendation of the State Insurance Institution, the amount of the State subsidy (section 31, subsection 6), the proportion of contributions to be paid into the equalisation fund (section 35, subsection 2), and issues all detailed regulations concerning the organisation and management of sickness insurance under the State Insurance Institution (section 41, subsection 3).

State Insurance Institution

The State Insurance Institution at Oslo is managed by a Committee of three persons, of whom one is a director appointed by the Crown, and two are members also appointed by the Crown, for a term of six years. It consists of seven permanent sections, one of which deals with sickness insurance in particular. Two medical officers are attached to the Institution. Its administrative expenses are met by the Treasury (section 41, subsection 4). The Storting decides on the proportion of these expenses which are to be borne by the insurance funds. The Institution has competence to supervise sickness insurance, accident insurance, and the insurance of fishermen and seamen. With respect to sickness insurance in particular, it is responsible for the central management of the district funds, the control of their administration, and in general for supervision of the observance of the law. The approved funds must submit to the supervision of the Institution in the same way as the district funds (section 63, subsection 1).

The Institution examines the accounts of the district funds submitted to it (section 39), as also those of the approved funds. If, on examining the documents submitted by an approved fund, it is held that the fund is working under conditions which offer inadequate security for the members, the institution may require the defects to be remedied (section 62, subsection 4). Sickness funds must submit to this supervision once a year; they must send to the State Insurance Institution a summary of their accounts and all necessary statistical data (section 39, subsection 4).

Communal Councils

The local supervision of sickness insurance institutions is exercised by the communal councils. In rural communes these functions are nearly always performed by the whole council. In towns, on the contrary, they are usually fulfilled by a committee elected by the council, and an appeal against the decisions of such committees may be taken to the whole communal council.

The local supervisory authorities have competence to examine the accounts of the funds (section 39), take the initiative in setting up district funds (section 40), and appoint members of the managing committee (section 44), managers, and auditors (section 53).

POLAND**COMPULSORY SICKNESS INSURANCE ACT OF 19 MAY 1920**

The putting into operation, administration, and general management of the sickness insurance system is entrusted to the Minister of Labour and Social Assistance. The supervision of the working of the institutions is in the

hands of the same Minister assisted by a Central Insurance Office and regional insurance offices, and also of the Minister of Public Health to the extent prescribed by the principal health laws.

Central Insurance Office

According to the Decree of 9 July 1924, the supervisory functions reserved more particularly to the Central Insurance Office include the following:

- (1) The organisation of the regional insurance offices.
- (2) The supervision of the work of the regional offices and, in the last resort, exercise of supervision over the funds subject to the supervision of the regional offices.
- (3) The organisation of sickness funds and federations of funds and the appointment of commissioners responsible for preparing the establishment of these institutions.
- (4) The supervision of the work of federations of funds.
- (5) The drafting of regulations concerning the administrative and technical working of sickness insurance.

Regional Insurance Offices

Three regional insurance offices have been set up at Warsaw, Poznan, and Lwow, subordinate to the Central Office at Warsaw. These offices have the following functions:

- (1) They must see to it that the sickness funds observe the law and the rules
- (2) They exercise general supervision of insurance business and supply any information required in this connection.
- (3) They supervise the activities of the sickness funds connected with curative treatment.

The insurance offices have power at any time to check the working and accounts of the funds; to order the authorities of the fund to carry out their duties; to appoint commissioners or instructors, and appoint provisional authorities for the fund pending its organisation; to confirm the appointment of managers; in cases of abuse or malpractice to suspend the authorities of the fund from the exercise of their functions, and appoint commissioners to set in order the affairs of the fund, and to proceed to new elections in the event of the elected authorities refusing, in spite of a summons, to fulfil the duties prescribed by the law, and also in the event of employers or insured persons refusing to elect their representatives, to appoint provisional authorities for the fund, in every case taking into account the proportion between the two groups fixed by the law; to impose an increase of contributions up to the amount necessary to meet the expenses on compulsory benefits; and to issue the local regulations necessary for the administration of the law.

The regional funds may further issue instructions respecting the finances, the accounting of the funds, and the uniform recording of insurance statistics, approve the rules of funds and federations of funds, give assistance to the funds; and invite the local government authorities to collaborate in the administration of the law, and in particular in the organisation of insurance institutions (section 100).

Ministry of Public Health

The Ministry of Public Health is represented in each regional insurance fund by the director of the regional health office (section 99).

In accordance with the Decree of 16 June 1921 defining the conditions in which supervision of the work of the funds with respect to medical assistance is exercised, the representative of the Ministry of Public Health may instruct the medical inspector, the pharmaceutical inspector, and the district medical officers to undertake certain functions of supervision. He may require the regional office to supply any documents, books, or other materials.

PORTUGAL

DECREE NO. 5640 OF 10 MAY 1919 CONCERNING THE ORGANISATION OF THE INSTITUTE FOR SOCIAL INSURANCE AND PUBLIC WELFARE

Supreme supervision of the administration of all compulsory insurance legislation is in the hands of the Institute of Social Insurance and Public Welfare attached to the Ministry of labour. The Institute supervises the working of the sickness insurance mutual benefit societies through the medium of the Social Welfare Inspectorate, which is subordinate to it. The Insurance Institute is managed by an administrative council of 11 members, presided over by the Minister of Labour. For purposes of financial supervision it acts through a supervisory council consisting of:

- (a) A representative of banking companies
- (b) Six members elected every three years by the Senate, the Chamber of Deputies, the Superior Administrative Court, the Public Credit Commission the Supreme Appeal Court, and the Supreme Court of Justice.
- (c) The Administrator-General of the General Deposit Fund (section 1, subsections 2 and 3).

The Institute has 12 departments, including a special Sickness Insurance Section (section 3). With respect to the supervision of sickness insurance institutions this Section has competence among other things:

- (1) To supervise and check the regular registration of members of mutual benefit societies.
- (2) To promote the establishment of mutual benefit societies, and examine and approve their rules and relations with the competent authorities.
- (3) To supervise the working of the mutual benefit societies, and to recommend to the administrative council the necessary measures for the satisfactory working of the institution.
- (4) To draw up annual reports on the basis of the activities and discussions of the general meetings of the mutual benefit societies (section 15).

ROUMANIA

ACT OF 25 JANUARY 1912 ON THE ORGANISATION OF CRAFTS, CREDIT AND WORKERS' INSURANCE¹

The supervision of the sickness insurance system is exercised by the Central Office for Crafts, Credit and Workers' Insurance at Bucarest, which acts both as the supervisory authority and the insurance carrier. It is subordinate to the Ministry of Labour, Co-operation and Social Insurance, which has power to suspend its decisions and require it to re-examine any question (section 203).

The Central Office is administered by an administrative council of 13 members appointed by Royal Decree for a term of seven years as follows:

- (a) Two members appointed by the Minister of Finance and seven by the Minister of Labour, Co-operation and Social Insurance.
- (b) Two employers, appointed by the Minister of Labour, Co-operation and Social Insurance and chosen from a list of six employers submitted by the Employers' Association.
- (c) Two artisans or workers appointed by the Minister of Labour, Co-operation and Social Insurance and chosen from a list of delegates, one for each guild, elected by the general meeting of the guild (section 194, subsection 1).

The external service of the Office comprises inspectors mechanical and mining engineers, medical inspectors, and auditors (section 206).

With respect to sickness insurance, the Central Office is responsible for administering the Sickness Insurance Fund and of supervising and controlling

¹ The Act applies to the territory of the former Kingdom, and, since the promulgation of the Act of 9 April 1921, also to Bessarabia.

the independent societies and mutual benefit societies attached to State, departmental and communal factories and undertakings (section 193)

The administrative council of the Central Office has competence to examine the financial estimates and annual reports of the brotherhoods, guilds, and mutual benefit societies. In view of the results for the previous year it may increase or reduce for all guilds, or certain of them, the weekly contribution for sickness insurance and funeral benefit (section 126). The Office has the right to convene the general meeting of the guild, as of the brotherhood, whenever it considers necessary (sections 90, subsection 3, and 75).

It may address a reasoned warning to the administrative councils of the guilds or federations of guilds and the committees of the brotherhoods. It also has power to dissolve the committee of a brotherhood, or the administrative council of a guild or federation which has received two such warnings, and in this case it appoints a provisional committee or council, and must convene a general meeting for the election of a new committee or administrative council (section 96)

RUSSIA

DECREE CONCERNING THE PEOPLE'S COMMISSARIAT OF LABOUR, 1923, No. 103-104. DECREE OF 6 FEBRUARY 1926 CONCERNING THE FEDERAL SOCIAL INSURANCE COUNCIL. DECREE OF 5 JANUARY 1924 OF THE R.S.F.S.R. COMMISSARIAT OF LABOUR CONCERNING THE SOCIAL INSURANCE DEPARTMENTS IN THE PEOPLE'S COMMISSARIAT OF LABOUR FOR THE R.S.F.S.R. AND THE COMMISSARIATS OF LABOUR OF THE AUTONOMOUS REPUBLICS, No. 1/1400. PROVISIONAL DECREE OF 31 DECEMBER 1924 OF THE R.S.F.S.R. PEOPLE'S COMMISSARIAT OF LABOUR CONCERNING PROVINCIAL (REGIONAL) INSURANCE FUNDS, No. 200/1138. CIRCULAR OF 27 MARCH 1923 CONCERNING THE RELATIONS BETWEEN LABOUR INSPECTION AND THE SOCIAL INSURANCE AUTHORITIES, No. 127/30. DECREE OF THE PEOPLE'S COMMISSARIAT OF SOCIAL WELFARE CONCERNING THE TRANSPORT INSURANCE DEPARTMENT, No. 63, 1922.

The centre of the social insurance system, which covers all physical risks as well as the risk of unemployment, is the Central Department in the U.S.S.R. People's Commissariat of Labour, which is the supreme supervisory authority for all social insurance in the Soviet Union. Attached to this Department there is a Federal Social Insurance Council which has competence to lay down general principles for the work of the Department.

The Federal Republics forming the Soviet Union have supervisory authorities of a similar type, namely, principal insurance departments in the Commissariats of Labour and insurance councils.

Local supervision is exercised by the provincial (or regional) social insurance authorities, which are not uniform in structure throughout the territory of the Union, by the labour inspectors, and by the organs of the Commissariat of Finance.

The transport funds are not supervised by the ordinary supervisory authorities but by the Central Transport Department, which forms part of the Central Social Insurance Department in the People's Commissariat of Labour.

Central Social Insurance Department and Principal Insurance Departments in the Federal Republics

The Central Social Insurance Department forms part of the People's Commissariat of Labour for the U.S.S.R. The chief of the department is appointed by the Commissariat of Labour in agreement with the Central Federal Trade Union and must be a member of the Council of the People's Commissariat of Labour.

This Department directs the working of, and exercises supervision over, all the local social insurance organs. It has the right to draft Bills, which are submitted to the Federal Insurance Council for approval, to publish within the framework of existing legislation orders, instructions and decisions, and to repeal or modify the orders and decisions of the principal insurance departments in the Federal Republics.

Among other things the Central Department must supervise the administration of the law, approve and check the financial estimates and other accounts of the insurance funds, fix the rates of contribution, the rates and methods of granting benefits, the regulations for administration and presentation of annual financial reports and statistical reports. It must also constitute and administer the Federal Reserve Fund.

The Central Department carries out its obligations under the law through the medium of the principal departments, which have been set up in the Soviet Republics of Russia, the Ukraine, Transcaucasia, White Russia, Uzbek, and Turcoman. Each of these is managed by an official appointed by the People's Commissariat of Labour for the Republic in agreement with the Trade Union Council for the Republic. These bodies supervise the local insurance authorities within their area, make grants to insurance funds which have suffered a deficit, and issue orders and instructions within the framework of general legislation and in accordance with the directions of the Central Department.

In some of the Federal Republics, for instance, the R.S.F.S.R., insurance departments are attached to the local organs of the Commissariat of Labour, and in the autonomous Republics to the Commissariats of Labour, with power to supervise the working of the institutions subordinate to them. Thus the Social Insurance Department for the north-west region, with headquarters at Leningrad, directs and supervises insurance in all the provinces included in this administrative sub-division.

Federal Social Insurance Council and Social Insurance Councils of the Republics

The work of the Central Department is governed by the principles laid down by the Federal Social Insurance Council. This Council was set up by a Decree of 6 February 1925 of the Central Executive Committee and the U.S.S.R. Council of People's Commissaries, with a view to enabling the authorities for national economy to participate in the management of the social insurance system.

This Council consists of an equal number of representatives of the Central Federal Trade Union Council and the chief authorities for national economy, namely, four representatives of the Central Federal Trade Union Council, two representatives of the Supreme Economic Council, one representative of the People's Commissariat of Finance, and one representative of the People's Commissariat of Transport. The president is a representative of the People's Commissariat of Labour. In addition to these persons, the Council includes one representative of each of the Commissariats of Public Health of the Federal Republics who attend in an advisory capacity.

The functions of the Federal Council include those of examining and approving the policy of the Central Department, checking its accounts and annual reports, and studying the draft Bills and approving the orders and instructions prepared by the Department. It also has the right to interpret Soviet insurance legislation, to examine complaints on the decisions of the insurance councils of the Federal Republics, and to decide on the investment of funds.

The members of the Council may appeal against its decisions within twenty-four hours to the Council of the People's Commissariat of Labour. The decision remains in force unless it is repealed by the latter Council within seven days. An appeal may be taken to the U.S.S.R. Council of People's Commissaries against any decision of the Council of the People's Commissariat of Labour or the Federal Social Insurance Council.

The Social Insurance Councils attached to the six People's Commissariats of Labour in the Federal Republics have similar functions, but their competence, like that of the People's Commissariats of Labour, is limited to the territory of the Republic. The composition of the Insurance Council of a Republic differs from that of the Federal Council in that it includes a representative of the Commissariat of Public Health.

Provincial and Regional Social Insurance Authorities

The provincial and regional social insurance authorities are not uniform in structure. In the R.S.F.S.R., Uzbek, and Turcoman, the management and

supervision of insurance institutions in each province are entrusted to provincial insurance funds with their headquarters at the chief town of the province (Decree of 31 December 1924). Where the division into governments has been abolished, these functions are performed by the area funds (Ural, Ukraine and White Russia). In Transcaucasia, which is not divided into provinces, the insurance departments for the Republics of Armenia, Azerbaijan, and Georgia act as the local supervisory authorities.

These various authorities differ, not as regards competence, which is the same for all of them subject to certain reservations, but as regards composition. Thus the provincial funds are managed by committees elected at the trade union congresses and assisted by supervisory committees also appointed by these congresses. The provincial offices and departments of Republics, on the contrary, are managed by officials or managers appointed by the competent authority in the People's Commissariat of Labour in agreement with the inter-trade union organisations.

In the R.S.F.S.R., according to the Provisional Decree of the People's Commissariat of Labour of 31 December 1924, the provincial funds have competence to direct and supervise the work of the local funds and to supervise the administration of social insurance legislation. Among other things, they have the right to issue regulations and instructions concerning the administration of insurance laws, to take the initiative in setting up institutions, and to confirm the appointment of presidents of the managing committees of the funds.

With respect to supervision, the provincial funds have competence to supervise the work of the insurance funds and put into operation the provisions of the law and decisions of the Federal Conference. They check and confirm the periodical reports of the institutions, inspect the general working of the funds and their financial situation, book-keeping and accounts. They also examine complaints of irregular action on the part of the committees and of irregular election of the managing and audit committees.

Labour Inspectors

The supervisory authorities are assisted in their work by the labour inspection officials. According to the Circular of the People's Commissariat of Labour, 27 March 1923, these officials have competence, among other things, to classify undertakings, supervise the sanitary conditions of undertakings, examine the social insurance records, and supervise the due payment of contributions. The inspectors notify the funds of any contraventions of labour protection legislation and inform them of the fines imposed on employers.

Supervision of Transport Funds

The supreme authority for the management and supervision of the work of the transport sickness funds is a special service in the Central Social Insurance Department of the U.S.S.R. People's Commissariat of Labour. This service is managed by a council of three persons, two of whom represent the central committees of the Railwaymen's and Seamen's Unions respectively, and the third is a president appointed in agreement with these two committees and confirmed by the chief of the Central Social Insurance Department.

The transport insurance service is responsible for the general management of the transport funds and the supervision of the administration of insurance legislation by these institutions. It gives the transport funds the necessary directions and instructions, and settles any disputes that may arise between them.

SERB-CROAT-SLOVENE KINGDOM

WORKERS' INSURANCE ACT OF 14 MAY 1922

The only statutory insurer against the risks of sickness, invalidity, old age, death, and accidents is the Central Workers' Insurance Institution, the local institutions merely act as its local organs.

The work of the Central Institution and the local institutions is under the supervision of the Minister of Social Affairs. The local institutions are thus subject to twofold supervision, since, on the one hand, the Central Institution directs their working, while, on the other, they are subject to the Minister who is competent for social questions. An account has already been given of the functions of the Central Institution and its relations with the local institutions.¹ All that need be indicated here is the manner in which the Government supervises the insurance system.

Under the Act the institutions must send regular reports to the Minister of Social Affairs. Thus the Central Institution and its local organs must send to the Minister a certified copy of the minutes of each session of the general meeting, the managing committee, and the supervisory committee not more than a fortnight after the holding of the session (section 181, subsection 1). Moreover, the Central Institution must send in its annual balance sheet and insurance statistics to the Minister not later than the end of June each year (section 184, subsection 3).

The Minister and his representatives in turn may at any time investigate on the spot the business operations and administration of property, books, registers, correspondence, and documents of the Central Institution, the local institutions, and the transport funds. In addition, they may undertake special audits of the accounts of the Central Institution and call for the balance sheet and statements concerning business, the list of sick members and recipients of payments, and an inventory of the assets of the Central Institution and its local organs. The Minister thus ascertains whether the institutions carry out the provisions of the law and rules, whether they fulfil their legal obligations, and exercise the necessary economy in administration (section 179, subsections 1 and 2).

The Minister of Social Affairs may order that the administrative bodies of the institutions should be convened, or convene them himself, and he may be represented by a delegate at their sessions (section 179, subsection 2). He may appoint temporary members of the administrative bodies whose election has been omitted (section 180), dissolve the administrative bodies and order a new election if the bodies are constituted contrary to the law or if they act in an illegal manner in connection with insurance business, and have the business of the institution carried on by his representatives pending a new election (section 179, subsections 3 and 4). Further, he has power to veto any resolution or decision of the administrative bodies contrary to the Act and Decrees in force, and to impose a fine not exceeding 600 dinars on any responsible official failing to comply with the law (section 182). Finally, if indications of any misdemeanour or crime appear in the management of the Central Workers' Insurance Institution or its local organs, the Minister must forthwith notify the competent authority (section 183).

An appeal may be lodged with the Council of State against any order, resolution or award of the Minister of Social Affairs (section 185, subsection 1).

SWITZERLAND

FEDERAL SICKNESS AND ACCIDENT INSURANCE ACT OF 13 JUNE 1911

Any sickness fund which makes an application and satisfies the conditions laid down in the law is entitled to a federal subsidy, and is then subject to supervision by the Federal Government exercised through the Federal Social Insurance Office, which is attached to the Department of National Economy.

The Federal Act empowers the Cantons to make sickness insurance compulsory in general or for certain groups of persons. They may set up public funds, due account being taken of existing mutual benefit funds, compel employers to provide for the payment of the contributions to the public funds by their workers who are liable to insurance, and transfer these powers to their communes (section 2). In the five Cantons or demi-Cantons which have made use of their powers under the Act, the supervision of the fulfilment of the above obligations and the working of the public funds is entrusted to the cantonal or communal authorities subject to the powers of the supreme supervisory authority, the Federal Social Insurance Office.

¹ See pp. 646-648.

Appenzell, Outer Rhodes

Supervision of the compulsory insurance system, which is administered by the mutual benefit funds and public communal funds, is in the hands of the Council of State. Decisions concerning liability to insurance, the payment of contributions, the establishment of public funds, and the constitution of funds which have to be taken by the communes are not valid until they have been approved by the Council of State and the Federal Council. Any agreements concluded by the funds must also be approved by the Council of State (sections 42 and 44 of the Order of 30 May 1924).

Appenzell, Inner Rhodes

The supervision of insurance is in the hands of a special commission, the *Standeskommission*, whose functions include those of approving the rules of the public funds and fixing the rates of medical and pharmaceutical benefits (sections 27 to 29 of the Order of 29 November 1920).

Basle Town

The Public Fund for the Canton of Basle Town is administered by the Department of Public Health and the Sickness Funds Commission, which also supervises the working of insurance.

The Sickness Funds Commission consists of six persons appointed by the Council of State for a term of three years. The president is the head of the Public Health Department, and three of the members must be representatives of insured persons. The manager of the Fund and its advisory medical officer take part in the meetings of the Commission in an advisory capacity.

The Commission takes part in the preliminary discussion of laws, orders, regulations, agreements, and schedules, and in the examination of all important questions affecting the Public Fund and private funds. It also takes part in the appointment of the employees of the Public Fund.

Once a year the Commission must draw up financial estimates and prepare a financial report and a report on the working of the Public Fund (section 26 of the Act of 12 March 1914, amended by the Acts of 10 October 1918 and 23 February 1922).

St. Gall

The general management and supervision of the communal sickness funds are in the hands of the communal councils. For this purpose every communal council must set up a committee which must include representatives of insured persons. This committee submits its accounts to the council once a year, which examines them and transmits them to the Cantonal Assembly for approval (section 8 of the Act of 28 May 1914, as amended on 20 November 1919).

Thurgau

Subject to the powers of the Federal Council and its organs, supervision of the obligations and working of the communal funds is in the hands of the Council of State. The communes may extend the scope of compulsory insurance, but all orders and regulations must be approved by the Council of State and the Federal Council. Similarly, contracts concerning transference from compulsory insurance to a private sickness fund and agreements concluded with medical practitioners and pharmacies must be submitted to the Council of State for approval (section 22 of the Compulsory Insurance Act of 24 April 1926).

International Tabular Summaries: Insurance Institutions

TABLE I — MANAGEMENT OF INSTITUTIONS. DISTRIBUTION OF REPRESENTATION AMONG INSURED PERSONS, EMPLOYERS, AND PUBLIC AUTHORITIES

Country	General meeting		Managing committee			Supervisory committee			Remarks
	insured	employers	insured	employers	public authorities	insured	employers	public authorities	
AUSTRIA District funds	Min. $\frac{2}{3}$	Max. $\frac{1}{3}$	Min $\frac{2}{3}$	Max $\frac{1}{3}$	—	Min. $\frac{2}{3}$	Max $\frac{1}{3}$	—	<i>District and works funds</i> The distribution of seats is proportional to the sharing of the contribution by insured and employers. The general meeting of a fund with more than 300 members is composed of delegates
Works funds	do.	do	do.	do	—	do	do	—	<i>Guinea funds.</i> In funds insuring only persons belonging to a single guild, the general meeting of the guild and the fund are identical, likewise the managing committee. The meeting is composed of delegates if the fund has more than 500 members. The number of members of the meeting is at least three the membership of the committee
Guild funds	—	—	—	—	—	—	—	—	The committee of the fund is composed of officials of the shipping department shipowners captains of ocean-going vessels, ship brokers, and chief merchants in ports.
Association funds	100 %	—	100 %	—	—	100 %	—	—	The insurance system is managed by the Ministry of Commerce, Industry and Labour and its local branches
BELGIUM (Seymen) Benefit fund	—	—	—	—	—	—	—	—	
BULGARIA.	—	—	—	—	—	—	—	—	
CHILE Local funds Mutual benefit funds. . .	— 100 %	— —	$\frac{1}{3}$ 100 %	$\frac{1}{3}$ —	$\frac{1}{4}$ —	— —	— —	— —	
CZECHOSLOVAKIA <i>General system:</i> District funds. Mutual benefit funds <i>Mine's insurance.</i> Mining funds	100 % 100 % % (min 30)	— — $\frac{1}{2}$	$\frac{8}{10}$ 100 % $\frac{8}{10}$	$\frac{2}{10}$ — $\frac{2}{10}$	— — —	$\frac{2}{10}$ 100 % $\frac{1}{3}$	$\frac{8}{10}$ — $\frac{4}{5}$	— — —	The general meeting is composed of delegates if the fund has more than 300 members. Employers are entitled to be represented on the supervisory committee.
ESTHONIA Works funds	100 %	—	100 %	—	—	—	—	—	

International Tabular Summaries :

TABLE II — STATISTICS RELATING TO THE NUMBER

Country	Year	All institutions			Territorial institutions				Trade works trade guild mining
		Number of insured	Num- ber of insti- tutions	Aver- age mem- ber- ship	Number of insured	Num- ber of insti- tutions	Aver- age mem- ber- ship	% of mem- bership of all insti- tutions	Number of insured
	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
AUSTRIA	1919	776,613	466	1,666	270 285	88	3,971	34.8	W.F. 47,370 G.F. 144,018 M.F. 22,567
	1924	1,274,644	199	6,405	562,712	67	8,399	44.1	W.F. 36,261 G.F. 257,837 M.F. 26,110
BELGIUM Seamen	1926	5,000	1	5,000	—	—	—	—	—
BULGARIA	1919	34,720	1	34,720	34,720	1	34,720	100	—
	1925	241,140	1	241,143	241,143	1	241,143	100	—
CHILE	1926	513,233	154	3,332	—	—	—	—	—
CZECHOSLOVAKIA	1923	2,168,473	235	3,284	1,638,785	306	5,355	75.6	W.F. 224,854 G.F. 112,743
ESTHONIA	1919	12,047	18	669	—	—	—	—	W.F. 12,047
	1925	34,349	31	1,108	—	—	—	—	W.F. 34,349
FRANCE Alsace-Lorraine . .	1919	341,384	264	1,293	184,733	27	6,841	54.1	W.F. 153,302 G.F. 3,349
	1924	439,414	246	1,786	257,439	27	9,535	58.6	W.F. 174,472 G.F. 4,911
Miners' insurance .	1913	242,894	224	1,084	—	—	—	—	M.F. 242,894
	1919	182,802	210	870	—	—	—	—	M.F. 182,802
	1923	265,232	227	1,168	—	—	—	—	M.F. 265,232
Seamen's insurance .	1913	134,462	1	134,462	—	—	—	—	—
	1919	107,976	1	107,976	—	—	—	—	—
	1924	132,048	1	132,048	—	—	—	—	—
GERMANY	1914	16,698,276	10,066	1,659	11,810,607	3,383	3,508	70.7	W.F. 3,408,196 G.F. 390,787 M.F. 916,081
	1919	17,240,624	9,203	1,873	11,823,487	3,147	4,766	68.6	W.F. 3,730,136 G.F. 287,227 M.F. 1,109,094
	1925	20,175,356	7,763	2,599	14,387,113	2,613	5,506	71.3	W.F. 401,928 G.F. 112,929 M.F. 817,845

Insurance Institution

OF INSTITUTIONS AND THEIR MEMBERSHIP

institutions funds (W.F.) union funds (T.U.) funds (G.F.) funds (M.F.)			Mutual institutions				Remarks
Number of institutions	Average membership	% of membership of all institutions	Number of insured	Number of institutions	Average membership	% of membership of all institutions	
(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)
114 187 28 31 45 27	415 770 806 1,170 5,730 967	6.0 18.5 2.9 2.8 20.2 2.0	292,373 391,724	49 29	5,967 10,059	37.6 30.7	Of 601 institutions in 1919 (211 in 1924), 438 funds established under the Workers' Insurance Act (172 in 1924) and 28 mining funds are covered by these statistics.
—	—	—	—	—	—	—	Estimate of the Shipping Department.
—	—	—	—	—	—	—	
—	—	—	—	—	—	—	
50 60	1,497 1,879	10.4 5.2	193,091	19	10,110	8.9	The figures for territorial institutions are based on statistics of district and rural funds, and those for mutual institutions on statistics of association and mutual benefit funds. No figures are available for two works funds.
18 31	669 1,108	100 100	—	—	—	—	
227 10 207 10 224 210 227	672 331 841 491 1,084 870 1,168	44.3 1.0 39.7 1.1 100 100 100	— — 2,592 — — — —	— — 2 — — — —	— — 1,296 — — — —	— — 0.6 — — — —	Alsace-Lorraine. As from 1 January 1924 the Alsace-Lorraine railway fund ceased to be subject to the Social Insurance Code, in virtue of the Act of 30 December 1923. The 2 postal workers' funds, with 2,150 members, are included in the 207 works funds existing in 1924, but have been disregarded in calculating the average membership of works funds.
— — —	— — —	— — —	— — —	— — —	— — —	— — —	Seamen's insurance. The number of insured comprises both registered and unregistered seamen.
5,524 917 146 4,960 910 128 4,279 778 51	621 420 6,271 758 317 8,665 796 569 16,036	20.4 2.3 5.5 21.6 1.7 6.4 16.9 2.2 4.1	172,609 290,680 1,122,541	66 58 42	2,615 5,012 26,727	1.0 1.7 5.6	The figures for territorial institutions are based on statistics of local general funds and rural funds. The figures for mutual institutions shown for 1914 are actually those for 1917, the 1914 figures not having been published. All the 1919 statistics include the Saar and Memel Territories. All the 1925 statistics exclude the Saar Territory and the parts of Upper Silesia transferred to Poland.

International Tabular Summaries:

TABLE II — STATISTICS RELATING TO THE NUMBER

Country	Year	All institutions			Territorial institutions				Trade works trade guild mining
		Number of insured	Num- ber of insti- tutions	Aver- age mem- ber- ship	Number of insured	Num- ber of insti- tutions	Aver- age mem- ber- ship	% of mem- bership of all insti- tutions	Number of insured
	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
GREAT BRITAIN .	1912	12,395,618	2,481	3,800	—	—	—	—	{ W.F. 120,970 T.U. 1,449,000
	1922	14,612,700	1,161	9,900	—	—	—	—	
NORTHERN IRELAND	1925	325,685	105	3,102	—	—	—	—	{ W.F. 2,183 T.U. 19,191
HUNGARY . . .	1919	560,510	173	3,240	473,911	97	4,886	84.5	G.F. 38,070
	1924	748,689	60	12,478	672,754	35	19,221	89.8	W.F. 27,383
IRISH FREE STATE	1923	420,399	84	5,005	109,553	26	4,213	26.1	{ W.F. 14,014 T.U. 54,243
LATVIA	1926	139,830	42	3,329	—	—	—	—	W.F. 139,830
LUXEMBURG.	1913	44,040	59	746	17,462	14	1,247	39.7	W.F. 25,997
	1919	37,710	56	674	13,010	14	929	34.5	W.F. 21,162
	1923	47,174	50	943	21,378	14	1,527	45.3	W.F. 25,341
NORWAY	1913	370,567	—	—	337,620	—	—	91.1	—
	1919	572,578	—	—	543,124	—	—	94.9	—
	1925	611,095	828	738	596,184	785	759	97.6	—
POLAND	1925	1,654,900	175	8,106	1,654,900	175	8,106	100	—
RUSSIA	1925	7,375,300	762	9,679	6,164,700	530	11,631	83.6	1,210,600
SERB-CROAT-SLOVENE KINGDOM	1924	459,541	24	19,157	447,367	22	20,335	97.4	—

Insurance Institutions

OF INSTITUTIONS AND THEIR MEMBERSHIP (continued)

Institutions funds (W.F.) union funds (T.U.) funds (G.F.) funds (M.F.)			Mutual institutions				Remarks
Number of institutions	Average mem- ber- ship	% of mem- bership of all institutions	Number of insured	Number of institutions	Average mem- ber- ship	% of mem- bership of all institutions	
(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)
100 224	1,200 6,400	0.8 9.9	12,395,618 14,612,700	2,481 1,161	3,800 9,900	100 100	The figures for mutual institutions (in the number of which branches are not counted) do not include the Deposit Contributors' Funds and the Navy and Army Funds of Great Britain and Northern Ireland. The figures of the number of trade institutions refer to 31 December 1918 and those of their membership to 1920.
3 12	728 457	0.7 5.8	325,685	105	3,102	100	
73 23	521 1,190	6.8 3.7	48,529 48,552	3 2	16,176 24,276	8.7 6.5	The statistics cover institutions in the general system and the Francis-Joseph Hospital (41,890 members in 1919 46,858 in 1924), but not transport funds (15,085 members in 1924), tobacco workers' funds (6,356 members in 1924), mining funds (63,685 members in 1924), and railway and postal workers' funds.
7 22	2,002 2,465	3.3 12.9	— 107,944	— 80	— 5,099	— 97.1	The figures of the number and membership of all institutions include the Deposit Contributors' Fund, the Military Forces Fund, exempt persons and migratory labourers. The figures for territorial institutions cover diocesan and county societies, and those for works funds comprise employers' provident funds and railway funds.
42	3,329	100	—	—	—	—	The statistics relate to December 1926.
41 38 32	634 636 792	59.0 64.0 53.7	581 547 455	4 4 4	145 137 114	1.3 1.5 1.0	
— — —	— — —	— — —	32,947 29,454 14,911	— — 43	— — 347	8.9 5.1 2.4	The statistics do not cover teachers' funds (180 in 1925) and railway funds (5 in 1925). The figures for mutual institutions include a few trade union funds (3 in 1925).
—	—	—	—	—	—	—	The statistics relate to the beginning of 1925. They do not cover the Polish parts of Upper Silesia.
232	5,218	16.4	—	—	—	—	The figures of the number and membership of territorial institutions relate to 1 July 1925: those of the trade institutions (railway funds) to 1 January 1925. The total number of insured on 1 September 1926 was 8,897,500 (7,433,800 in territorial funds and 1,463,700 in transport funds).
—	—	—	12,174	2	6,087	2.6	The figures of the number and average membership of territorial institutions refer to institutions subject to the Central Workers' Insurance Institution the figures for mutual institutions refer to 2 salaried employees' funds.

PART V

**SETTLEMENT OF DISPUTES ; OFFENCES
AND PENALTIES**

PART V

SETTLEMENT OF DISPUTES ; OFFENCES AND PENALTIES

INTRODUCTION

A social insurance law will cover hundreds of thousands, millions, or even tens of millions of wage-earners, according to the country. It necessitates the working of a complex system of institutions and affects the interests not only of the insured, but of employers, medical practitioners, dispensing chemists, etc. The administration of insurance laws must therefore in the ordinary course of events give rise to fairly numerous disputes, the causes of which will be discussed below.

There are two types of institutions for settling these disputes: supervisory authorities (whose working was studied in Part IV, Chapter III), and judicial authorities, which are sometimes the ordinary courts but more often special insurance authorities (referees and arbitration committees or insurance courts). The present purpose is to examine the nature, composition and powers of these authorities.

Compulsory sickness insurance imposes many important obligations on insured persons, employers, sick persons, insurance institutions, medical practitioners, etc., and the whole system cannot work regularly nor give the expected results unless these obligations are normally and exactly fulfilled by all concerned.

All insurance legislation must provide penalties, which will be discussed, for resistance, irregularity, fraud, and offences in general.

Part V will therefore comprise the following three Chapters: Chapter I, Causes of Disputes; Chapter II, Judicial Authorities; Chapter III, Offences and Penalties.

CHAPTER I

CAUSES OF DISPUTES

The subjects of the disputes arising out of the administration of compulsory sickness insurance legislation include the liability to compulsory insurance or admission to voluntary insurance, the payment of contributions, the determination of benefits, the working of the institutions, and the drafting and enforcement of contracts between insurance institutions and the medical profession:

§ 1. — Disputes concerning the Scope of Insurance

Compulsory insurance applies to workers who are employed in an occupation in another person's service under a contract of work and earn their living from this occupation. Its administration may therefore give rise to disputes concerning the undertakings liable, the nature and duration of the employment, or the individual qualifications of the persons employed.

Disputes concerning the definition of the scope of insurance are infrequent. Compulsory insurance applies as a rule to both industrial and commercial undertakings, thus evading the always difficult problem of drawing a line between industry and commerce. On the other hand, difficulties may arise if compulsory insurance does not cover agriculture. In this case there may be a question whether the compulsion applies to workers in industrial undertakings attached to large farms.

Sometimes, too, as in Japan, the scope of the law is determined with respect not only to the nature of the undertaking, but also to its size and the gravity of the risks it offers. Consequently, workers in factories where the work is not particularly dangerous are not liable to insurance. It is easy to understand that the determination of the degree of unhealthiness in a given undertaking may give rise to discussion and disputes. In fact, even if the unhealthiness of the work in an industry is duly established either by law or by judicial practice, the employer may yet claim that he uses preventive measures in his undertaking, and it is impossible

to avoid differences of opinion on the degree of effectiveness of such measures.

Disputes concerning the nature of the contract of the employment or the nature and duration of the work are much more frequent. As a rule, insurance is compulsory only for wage-earners, and it is often difficult to apply the legal definitions of home work, and of casual, subsidiary, seasonal, and temporary employment. Disputes may also arise out of the insurance institutions' determination of the maximum earnings or income up to which a worker is liable to insurance.

In addition to the possibility of differences concerning liability to compulsory insurance, there is that connected with affiliation to voluntary insurance. Under various sickness insurance systems persons formerly liable to insurance as well as certain other groups (non-working members of the family of an insured person, farmers, share farmers, small employers or artisans) have the right to insure voluntarily. Voluntary insurance is in principle open only to persons whose means do not exceed a certain maximum and who are in a satisfactory state of health. Their admission to insurance may give rise to disputes concerning the nature of their occupation, the determination of their income or earnings, or the results of the medical examination which they are generally bound to undergo.

§ 2. — Disputes concerning Contributions

The disputes to which the obligation to pay insurance contributions may give rise more often affect the employer than the insured person himself. The fact is that almost all modern social insurance laws have instituted the deduction of contributions at source, that is to say, they make it compulsory to deduct the insurance contributions from the insured person's wages. The employer thus becomes alone responsible to the insurance institution for the payment of the whole contribution, both his own share and that of the worker. The employer may find himself differing from the institution with respect to the method of calculating the wage or to the wage class in which the insured person is to be placed (under the many laws which provide for wage classes), and from the insured person with respect to the proportion of the contribution to be deducted from wages. Such disputes arise particularly in connection with temporary workers, intermittent workers, and workers employed by several employers during one and the same short period.

§ 3. — Disputes concerning Benefits

It is clear that the nature, amount, and duration of benefits are the most fruitful causes of disputes arising out of the administration of compulsory sickness insurance. These disputes may arise out of the conditions for obtaining benefit (waiting period) the payment of cash benefits (rates of benefit, alternative benefits, determination of the benefit and additional benefits), or, finally, the grant of benefits in kind (medical attendance, surgical treatment, the supply of drugs, hospital treatment, etc.).

The rates and character of benefits in cash and in kind are determined by the law, and the claim to benefit is established by a statement of the sick person and a medical certificate. In point of fact, disputes concerning the claim to benefit properly so called are exceptional (contradictory medical reports and insistence on his claim by the insured person), but as conditions are laid down for obtaining benefits or medical treatment, disputes may arise in connection with the calculation of the waiting period or the application of the exceptions allowed in several laws to enable insured persons who are out of work to retain their rights during all or part of the time they are unemployed.

The care with which the authorities fix the rates and duration of benefit markedly reduces the risk of dispute. Practically the only causes of dispute are delay in the payment of contributions and cases of over-insurance. The chief factor increasing the risk of disputes concerning benefits is to be found in the exceptions established by law under which the insurance institutions have power in particular circumstances to grant alternative benefits, reduce the benefit, or, on the other hand, to allow an additional benefit. As a matter of fact, many laws lay down that if it is necessary to treat the sick person in hospital, the cash benefit may be used by the insurance institution to pay the cost of maintaining him in a hospital or sanatorium. This is an obvious source of dispute, for the insured person may not merely contest the need for hospital treatment, but also the proportion of the cash benefit used by the institution to pay his fees, if he considers that this proportion is not fixed equitably. Further, the hospital treatment of an insured person suffering from a chronic disease and therefore needing prolonged treatment in a sanatorium may lead him or his legal representative to demand additional benefit so that he may be able to continue his medical treatment beyond the period laid down in the rules or the law. Similarly, the state of health of an insured person

may necessitate immediate treatment. In this case most laws allow him to request the institution to exempt him from the waiting period. Finally, if an insured person who is treated in hospital has dependants, he may apply to the fund to obtain an additional benefit for his family.

In spite of the precision with which the law is worded it cannot prevent disputes concerning benefits in kind (medical attendance, surgical treatment, the supply of drugs), the most frequent cause of dispute. In the first place it should be observed that although the standards of cash benefits may be fixed with sufficient exactitude by the law, those of benefits in kind on the contrary, are, as a rule, left to the discretion of the insurance institution, which in turn must rely on the medical profession. In other words, here, even more than in the case of cash benefits, the decision taken by the judicial authorities must be based above all on the facts. In addition to differences between insured persons and the insurance institution as to the choice of a doctor or treatment in a particular hospital, disputes concerning benefits in kind are caused by the apportionment between the institution and the insured person of the cost of medical and surgical attendance and drugs in cases where the insurance institution assumes only part of the cost of benefits in kind.

§ 4. — Disputes concerning the Administration of Insurance Institutions

The working of the insurance system centres about the sickness funds. Reference has already been made to the disputes that may arise between them and employers concerning the affiliation of insured persons and the payment of contributions, between them and insured persons concerning benefits, and between them and medical practitioners and dispensing chemists concerning the drafting and enforcement of contracts for organising medical and pharmaceutical services. A brief account may now be given of the disputes which may arise between the different administrative bodies of the funds, or between the funds and the supervisory authorities.

The insurance fund is usually managed by a meeting of the insured persons and employers (or their delegates), a managing committee and an audit committee. Disputes may arise in connection with the regularity of the convocation of the meeting or of the elections of the managing committee. There may be differences between

the audit committee and the managing committee as to their respective powers. Such differences are usually settled either by the meeting of the fund or by the supervisory authorities.

The administrative bodies of the fund may find themselves at issue with the supervisory authorities because they have exceeded their powers, taken decisions not in conformity with the law, regulations or rules, been guilty of irregular book-keeping, or bad financial management, or have adopted unsuitable schemes concerning, for instance, the introduction of additional benefits, the purchase or construction of hospitals, or the investment of the reserve fund. Such disputes of an administrative nature are within the competence of the supervisory authorities of first instance, who cancel or revise all irregular decisions and refuse to approve unsatisfactory schemes. If the powers of the supervisory authorities are inadequate, the decision is taken by the higher supervisory authorities (regional office, central office or minister), and it is only in rare cases that the courts are called upon to decide.

Disputes concerning the administration of insurance institutions, which tend to be many when the system is first started, gradually die down as the supervisory authorities give greater definition to the text of the law, draw attention to possible errors, indicate the best form of action, and carry out more completely their duty of acting as the technical and social advisers of the institutions.

§ 5. — Disputes concerning the Drafting and Enforcement of Contracts between Insurance Institutions and the Medical Profession

Without exaggerating the seriousness of disputes arising out of the relations between insurance institutions on the one hand and medical practitioners and dispensing chemists on the other, it is however necessary to indicate their importance.

The drafting of the contracts which usually govern the relations between insurance institutions and the medical profession raises various questions of capital importance to the satisfactory working of the insurance system. It is not merely a question of deciding on the system and form of remuneration of the medical practitioners who treat sick insured persons; it is also necessary to see to it that this remuneration is fair, or, in other words, makes allowance both for the social status of the profession and for the financial resources of the insurance institution. Here is an obvious source of litigation. But the intervention of the judicial authorities is required less in connection with the drafting of the contracts than

with the enforcement of their various clauses. The practical application of the tariffs established in the agreements between groups of medical practitioners and insurance funds often gives rise to disputes on the calculation of fees, particularly in cases involving special attendance, travelling, etc., whether the fund contests the accuracy of the accounts submitted by the doctor or whether the doctor refuses to accept the reductions effected by the authorities of the fund.

The supply of drugs is also of great importance. Collective agreements between insurance institutions and organisations of dispensing chemists determine the rates to be charged for drugs. The enforcement of these agreements and the observance of the rates may obviously give rise to similar disputes on points of professional interest to those which endanger the relations between the medical practitioner and the fund (questions of tariffs, free choice of chemists, etc.). The conditions under which the chemist considers that he should supply the required drugs "in their most economic form", and on occasion to substitute patent medicines, are often the cause of dispute.

CHAPTER II

JUDICIAL AUTHORITIES

§ 1. — Nature and Classification of Systems of Jurisdiction

The settlement of disputes concerning sickness insurance may be within the competence of the ordinary courts or of special judicial authorities (referees, arbitration committees or insurance courts) or of a mixed system involving both special authorities and the ordinary courts.

In the modern organisation of social insurance in general and sickness insurance in particular, the intervention of the ordinary law courts is limited. Although these courts offer every assurance of competence, in almost every country the legislature has preferred to make use of special judicial authorities to take cognisance only of disputes arising out of the administration of social insurance laws. These may be arbitration authorities or insurance courts.

Special arbitration authorities may be set up by the parties, who agree of their own free will to refer disputes to them for settlement. The law may invite the parties to refer their disputes to a referee or arbitration committee for which it has itself made provision, or it may compel them to have recourse to arbitration, in which case it may either leave them free to choose the arbitration authority or allow them only a limited choice.

In view of their practical knowledge of the questions connected with certain disputes, particularly insurance benefits, and of the participation of representatives of the interests concerned, these special arbitration authorities offer the advantages of rapid procedure. But the experience of several countries seems to have shown that the absence of professional judges, the frequent change of arbitrators,⁽¹⁾ and the insufficient provision for appeal procedure are disadvantages of special arbitration authorities, but do not occur in the case of the special insurance courts.

The chief differences between the *special insurance courts* and the ordinary courts are the following:

The collaboration of representatives of the groups concerned (insured persons, employers, medical practitioners), who are not professional judges, gives these authorities a knowledge of the needs of insured persons, the responsibilities of employers, and the conditions of the medical profession. The courts being specialised, they can offer, chiefly in connection with questions of the rights and obligations of the insured, a guarantee of speedy procedure which the ordinary courts — being burdened with cases of all kinds — cannot always give. Finally, the special courts may adopt rules of procedure which facilitate their working and reduce formalities and costs to the strict minimum. In addition, proceedings before special insurance courts are normally free of charge to the insured person, and, if not, the costs of an applicant who loses his case are insignificant.

To these arguments it has been objected that the lack of legal knowledge in the persons composing them is a disadvantage not only to the special arbitration authorities, but also to the insurance courts. The impartiality of the awards of these courts is doubted, because they include judges who do not belong to the profession, and further the question is raised whether the fact that the judges or arbitrators do not hold permanent office is not incompatible with uniformity of principle in the settlement of cases.

The examination of the composition and powers of the judicial authorities and the study of the actual texts will show what foundation there is for these objections. For the moment it need merely be observed that in practice the insurance courts in the States in which these institutions have reached a certain standard of organisation always include permanent judges with adequate legal training and experience. It seems that in practice the institutions set up solely for the settlement of insurance disputes give the parties as much guarantee of equity, legal efficiency and uniform judicial practice as the ordinary courts themselves can offer; and it may be repeated, because it is a point of importance, they offer more speedy procedure. At all events, a definite distinction must be drawn between arbitration authorities and insurance courts properly so called.

The national systems of jurisdiction may be classified in three groups according as they place insurance disputes solely under the authority of the ordinary courts, or, on the contrary, only of the special authorities, or make use of both the ordinary courts and special authorities.

GROUP 1: LAWS UNDER WHICH THE ORDINARY COURTS REMAIN
FULLY COMPETENT

With the exception of Belgium and France, in which special systems for miners and seamen are in force, this group includes only the general sickness insurance systems of Chile and Greece.

GROUP 2: LAWS IN WHICH SPECIAL JUDICIAL AUTHORITIES ARE
ALONE COMPETENT

This group includes the laws of the following countries France (Alsace-Lorraine); Germany; Hungary; Italy (new provinces); Japan; Lithuania; Luxemburg; Norway, Poland; Portugal; Russia; Serb-Croat Slovene Kingdom; Switzerland (Appenzell. Inner and Outer Rhodes).

As regards the classification of the laws of this group, certain exceptions should be observed. In Hungary disputes on the dietary of insured persons treated in public hospitals or hospitals considered as such are not within the competence of the ordinary authorities, but of the administrative authorities. In Japan disputes concerning contributions are settled directly by the head of the Department for Social Affairs. An appeal against his decision may be taken to the Minister for Home Affairs or the administrative courts. In Luxemburg disputes between sickness funds on the one hand and accident insurance associations, old-age and invalidity insurance institutions, communes or charitable institutions on the other, are settled by the Government subject to an appeal to the Council of State. In Russia the Supreme Court may, on the intervention of the Commissary for Labour, annul the decisions of the special courts which have already been carried into effect. In the Serb-Croat-Slovene Kingdom, disputes between employers and insured persons concerning the apportionment of contributions are settled by the administrative authorities acting as judicial institutions. These administrative authorities decide in the first instance, and an appeal against their decisions may be taken to the Minister of Social Affairs, whose decision is final.

These are the exceptions to the competence of the special judicial authorities in certain States, which nevertheless have been classified in the second group because the very limited powers allowed to the administrative authorities apply only in exceptional cases and do not affect the principle.

GROUP 3: LAWS INVOLVING A MIXED SYSTEM OF SPECIAL AUTHORITIES AND THE ORDINARY COURTS

Austria; Bulgaria; Czechoslovakia; Esthonia; Great Britain and Northern Ireland; Irish Free State; Latvia; Roumania; Switzerland (Basle Town and St. Gall).

In this last group of laws there are very marked differences between the composition and powers of the various types of judicial authorities. A very brief reference may be made to the particular features of certain laws in which the two systems of jurisdiction are in use side by side. In Esthonia the ordinary courts have the same powers as those held by the workers' insurance councils. In Great Britain and the Irish Free State the special arbitration authorities intervene when the rules of the approved societies lay down that disputes between an insured person and the society (particularly with respect to benefits) must be referred to a referee or arbitration authority. Appeal is allowed to the Ministry of Health or the Irish Insurance Commission. In the rare cases where the rules fail to provide for arbitration, the ordinary courts (county courts, courts of summary jurisdiction) have competence. In practice many disputes are settled by mediation of the higher administrative authorities (Minister of Health or the Irish Insurance Commission). In Latvia all disputes are decided by the Ministry of Social Welfare, with a right of appeal to the Administrative Department of the Senate. In Austria, Bulgaria, Czechoslovakia, Norway, and Poland the position is rather different, and here the special authorities play a predominant part.

§ 2. — Composition of the Judicial Authorities

COMPOSITION OF ARBITRATION AUTHORITIES

In several compulsory insurance systems — for instance, in Austria, Bulgaria, Great Britain and Northern Ireland, the Irish Free State, Norway, Poland, and Switzerland (Appenzell, Inner and Outer Rhodes) — the insurance institutions are bound by law to provide for or set up an arbitration authority.

As a rule the special arbitration authorities consist of representatives of insured persons and employers, and in certain cases of doctors. Sometimes they are assisted in their work by public officials or magistrates (Bulgaria, Poland). According to the kind of insurance, the special arbitration authorities may also include, in addition to insured persons and employers, representatives of

the communal or district authorities (Norway, Switzerland (Appenzell)). In the latter Swiss Canton, however, the arbitration authorities do not include employers' representatives, as employers are not liable to pay contributions.

Although this is the most ordinary form of organisation, there is another which consists of appointing a referee or arbitration committee for each dispute (Great Britain and Northern Ireland and the Irish Free State). No member of the committee of management of the approved society, and, in general, no person directly or indirectly interested in the business of the society, can act as a referee.

COMPOSITION OF INSURANCE COURTS

The composition of an insurance court must depend on the necessity of obtaining regular working, fair awards and uniform judicial practice. This result may be achieved by a proper distribution of the seats between professional judges and representatives of insured persons and employers.

For the special insurance courts of the first instance, which deal with disputes on questions of fact as well as on points of law, it is important that numerical preponderance should be given to the representatives of the groups concerned, provided that they are under the direction of person with legal qualifications. The chairmanship of the court is thus entrusted to a judge in the administrative or judicial system, whose technical knowledge and experience of insurance problems will facilitate the work of the court.

In the second instance the more serious nature of the disputes requires a somewhat different form of court. On the one hand, the intervention of judges must be more important, and on the other hand stricter rules concerning the choice of the assessors should apply so as to effect a selection — i.e. exclude from these authorities representatives of insured persons and employers who are without the necessary qualifications.

As regards the composition of the highest special authorities, whose chief purpose is to ensure the uniformity of judicial practice, there can be no hesitation in asserting that preponderance should be given to professional judges.

The methods adopted in the chief national systems will be briefly examined.

A first method — that adopted in Germany, where the competence of the insurance courts covers all disputes — involves a distinction between the composition of the authorities who settle judicial

disputes and that of the authorities who are competent for administrative disputes. In the authorities of first instance the assessors have no powers with respect to administrative disputes, but in the second instance the administrative chamber of the insurance office consists of two permanent judges and two assessors, and the judgment chamber of one permanent judge and two assessors. In the supreme authority the distribution is as follows:

	Judgment committee	Administrative committee	High commission (uniformity of practice)
Permanent officials and judges	3	4	6
Assessors	3	3	5

The intention of the German law to strengthen the structure of the insurance courts is obvious. As soon as a dispute becomes serious or affects the general working of insurance, the professional judges are given preponderance. This is the central problem of the composition of insurance courts, and wherever the legislature considers that the employers' or workers' representatives may be inadequate, it restricts their influence while respecting the principle of their collaboration. Thus, in Hungary, the participation of professional judges is in the proportion of one to three in the authorities of first instance, three to five in those of second instance, and nine to four in the highest authority. In Roumania the groups concerned collaborate only in the authorities of first instance, whereas in those of second instance it is the members of the administrative council of the Central Insurance Office who judge. The Yugoslav system is even more cautious, for the assessors have authority only in the first instance, the courts of second instance consisting solely of professional judges.

Thus the preponderance of professional judges in special insurance courts depends on needs. In Czechoslovakia, for instance, considerable place is given in the courts to assessors, who sit in the authorities of every instance. The same applies in Japan, where the authorities have not hesitated to place insured persons and employers on the insurance courts. There are three instances, and in each the assessors outnumber the professional judges. It should be stated, however, that under Japanese law the assessors on the insurance courts are not all insured persons or employers, for in each instance a third of the seats are reserved for persons with expert knowledge or recognised experience.

METHOD OF APPOINTING JUDGES FOR SPECIAL JUDICIAL AUTHORITIES

Selection of Referees

A common procedure for the settlement of disputes consists in the appointment of a referee by the institution with the proviso that the insured person, if he objects to the referee appointed by the society, may nominate one himself, and the two persons so appointed shall appoint a third either by agreement, or, failing agreement, by lot (Great Britain and Northern Ireland and the Irish Free State).

Another system of appointing the special arbitration authorities is that of having the members elected by the general meeting of the fund or of the district funds. This method presupposes considerable experience on the part of the authorities of the funds, for it means that the vote of the general meeting must ensure a fair representation of the various interests at stake, in particular those of insured persons and employers. With a few slight differences, this is the method usually adopted in the States which have set up arbitration authorities. It should be mentioned, however, that in Norway the members of the arbitration committees, of whom there are three, are chosen by the municipal authorities for the commune in which the sickness fund has its headquarters. A similar provision applies in Switzerland in the two Appenzell Cantons.

Appointment of Employer and Worker Members of Insurance Courts

In the insurance courts the employer and worker members may be elected by secret ballot of the insured persons and employers respectively who are covered by the court, or appointed by the public authorities (municipal authorities, prefects, or provincial governors, ministers). Sometimes the appointments are made from lists submitted by the groups concerned.

In Federal States, where it is necessary to provide for the representation of several political entities, a certain number of the assessors in the highest special authority are appointed by the Federal Chambers (Germany) or Central Commissariats (Russia). For Russia it should be added that the assessors are appointed by the local, provincial or central political authorities, in agreement with the trade union or inter-trade union organisations.

Appointment of Permanent Judges

In special insurance courts the permanent judges are appointed by the authorities specified in the law. In Germany, for instance, the permanent judges in the insurance offices (the first instance) are appointed on administrative lines, being officials of the insurance offices. In the second instance the permanent members of the superior offices are chosen from among public officials, and their appointment is their principal office. The president of each superior insurance office is appointed for life. The President of the Republic himself appoints, on the recommendation of the Council of Ministers, certain permanent members of the supreme authority (the Federal Insurance Office). The other permanent members, being officials, are appointed by the Minister of Labour. The permanent judges of the special insurance courts are appointed by the competent Minister or the Council of Ministers.

A similar system to that in Germany applies in Czechoslovakia, Esthonia, Italy, Lithuania, and Portugal, for the authorities of second instance and the highest authorities, and in Japan, Roumania, and the Serb-Croat-Slovene Kingdom, for all the authorities — that is to say, including those of first instance.

§ 3. — Powers of Special Judicial Authorities

The special judicial authorities may be called on to settle certain types of disputes — for instance, those concerning benefits — or, alternatively, to settle all disputes connected with insurance. The judicial powers of these special authorities will depend mainly on their organic constitution. The more complete this is, and the more guarantees of equity, of constancy, and uniform practice it offers, the wider will be the power of the special authorities.

The permanent authorities which are placed under the direction of professional judges enjoy the independence of judges so far as the performance of these functions is concerned, and comprise one or more appeal instances, to which appeals against the decisions of the authorities of first instance are taken. They settle not only disputes affecting the parties to the case, but also issues which affect, in addition to the interests of the parties, the working of the insurance system as a whole. On the contrary, *ad hoc* authorities, or even permanent authorities which do not include professional judges, and comprise only one instance, settle only disputes affecting the parties to the case. Their decisions are valid as a

final judgment only as between these parties. Thus, the constitution of the authorities is what primarily determines their powers.

REFEREES AND ARBITRATION COMMITTEES

Arbitration committees which do not include at least one judge in the administrative or judicial system, and against whose decisions no appeal can be allowed, have relatively limited judicial powers. They settle disputes between insured persons and insurance institutions concerning benefits. Thus, the arbitration committees set up in each sickness insurance office in Austria and Poland, which consist of representatives of insured persons and employers, are the only authority in Austria, and the chief authority in Poland, to decide disputes concerning benefits, all other classes of disputes (except those concerning the enforcement of contracts with medical practitioners) being within the competence of the administrative authorities (general political authorities in Austria, insurance offices in Poland). Similarly, in Bulgaria the competence of the arbitration council, consisting of the magistrate and representatives of insured persons and employers, is limited to disputes concerning medical attendance and the payment of cash benefit.

The arbitration authorities for which the rules of the approved societies in Great Britain and the Irish Free State may make provision, have wider powers because they settle not only disputes on benefits but all other differences arising out of a decision of the approved society with respect to a member or affecting his membership. Nevertheless, even when provision is made for several instances, an appeal against the decision of the arbitration authorities may be taken to the Minister of Health. If the appeal is allowed, an expert selected from a list of lawyers is appointed by the Minister finally to settle the dispute.

INSURANCE COURTS

Special insurance courts, which have more in common with the ordinary courts or the administrative authorities, as a rule take the final decision in disputes concerning benefits. As the constancy of judicial practice, and its conformity with the law, is ensured by the collaboration of professional judges, and by appeal to the higher insurance court, decisions on benefits may be taken in the last resort by these courts. In certain countries, however, classes of disputes other than those concerning benefits are also referred to

the insurance courts. This applies to disputes which, although arising out of a particular case, may affect the working of the whole insurance system, such as disputes on wage classes and the contributions appropriate thereto, or disputes between several insurance institutions, or between an insurance institution and another public body. In such disputes, the decision must be rendered as a final judgment for all, and not only for the parties to the case, and hitherto every system has placed them within the competence of the administrative authorities. In countries where the principles of administrative jurisdiction have gradually been recognised, however, autocratic decision by the head of the administrative authorities has given way in particularly important cases to decisions taken by bodies organised and given independence on the model of judicial councils.

In most countries with insurance courts in which those concerned, employers and insured persons, are represented at least on the authorities of first instance (as in Hungary, Japan, Luxemburg, Norway, Roumania, and the Serb-Croat-Slovene Kingdom), the insurance courts have power in the classes of disputes in which the subjective rights of the parties to the case are primarily affected, while disputes whose settlement affects the insuring group as a whole are settled by the administrative authorities. Thus, disputes concerning the benefits payable by the insurance institutions are always within the competence of the insurance courts, whereas those concerning liability to insurance, the fairness of the contribution, or the apportionment of the contribution between employers and insured in accordance with the law, are settled by the administrative authorities.

Some States use the insurance courts both as judicial authorities properly so called and as administrative authorities. In Czechoslovakia the arbitration committees and insurance courts take cognisance of cases involving individual interests. The decision in questions affecting general interests, on the contrary, lies with the president of the insurance court, while administrative disputes such as those arising out of the liability to insurance are within the competence of the administrative authorities.

In France (Alsace-Lorraine) and Germany the law empowers the insurance offices to settle all disputes arising out of the administration of the various branches of social insurance (sickness, invalidity, pensions). The insurance offices act both as supervisory authorities and judicial authorities, and comprise three instances. At each step various bodies act respectively as judicial instances for settling

disputes involving individual interests, and administrative authorities for disputes on questions of general interest. It should be added that disputes involving general interests will be settled according to their nature and importance, either by a board of three or more members, or by a single official acting on behalf of the insurance office. In this way the legislature has established a complete and compact system of jurisdiction comprising the whole series of instances. At the same time the insurance courts are given independence in that their powers are sufficient for them to deal with all disputes arising out of the working of social insurance.

§ 4. — The Competent Authorities to Settle Disputes concerning Benefits

The most frequent disputes are those concerning benefits. They urgently demand fair and speedy settlement, for when an insured person falls ill he must be sure of obtaining the necessary care without delay, as well as the benefits due to him for his maintenance and that of his family. If a dispute arises in this connection, any delay in settlement will seriously reduce the value of insurance. The question had seemed so important that in every country the legislature has endeavoured to provide for the rapid settlement of disputes on benefits. The uniformity of the methods used and systems adopted is noteworthy.

The first method is that of giving competence in questions of benefits to the special judicial authorities for insurance: the referee or arbitration committee, and the insurance court.

The competence of the ordinary courts as regards benefits has been maintained only in Chile, Greece, and the Swiss Cantons of Basle Town and St. Gall.

Disputes concerning benefits are submitted to:

- (1) *Referees or arbitration committees* in the following countries:
Austria; Bulgaria; Czechoslovakia; Great Britain and Northern Ireland; Irish Free State; Switzerland (Appenzell, Inner Rhodes and Outer Rhodes).
- (2) *Special insurance courts* in Czechoslovakia; Esthonia; France (Alsace-Lorraine); Germany; Hungary; Italy; Japan; Lithuania; Luxemburg; Norway; Poland; Portugal; Roumania; Russia; Serb-Croat-Slovene Kingdom.

Thus, the vast majority of sickness insurance systems make use of special judicial authorities for the settlement of disputes concerning benefits.

§ 5. — The Composition and Powers of Judicial Authorities in National Legislation

After this very general survey of the problem raised by the establishment and working of judicial authorities, the national laws will be examined country by country. In each case an indication will be given of the general structure of the system, after which the composition and powers of each authority will be described.

AUSTRIA

ACT OF 30 MARCH 1888, TEXT OF 20 NOVEMBER 1922

The system of jurisdiction includes special arbitration authorities and administrative authorities. The organisation of the authorities depends on the nature of the dispute:

- (1) Arbitration courts set up in each sickness fund deal with disputes concerning benefits.
- (2) Conciliation committees deal with disputes between funds and medical associations.
- (3) Arbitration courts in the accident insurance institutions deal with disputes between a fund and a medical practitioner.
- (4) The general political authorities deal with disputes concerning contributions and disputes between funds and other public bodies.

Arbitration Courts

Composition

The composition of the courts must be defined by the rules of each fund. In actual fact the rules of the sickness funds usually leave this question to the decision of the general meeting. Thus, the composition of these authorities is the result of a compromise between insured persons and employers.

Powers

Disputes on benefits are settled solely by the arbitration courts, and no appeal against their decisions is allowed. The execution of the award is entrusted to the ordinary courts (section 41, subsection 2).

Conciliation Committees

Composition

The composition of the conciliation committees is determined by Decree of the provincial governor on the basis of equal representation of those concerned. The chairman of the committee is a public official, who must not be a medical practitioner.

Powers

If there is a difference of opinion between a sickness fund or a federation of sickness funds, on the one hand, and a medical practitioner on the other, concerning the conclusion of a medical contract or its enforcement, the provincial governor convenes the competent conciliation committee.

Arbitration Courts of Accident Insurance Institutions

Unless expressly agreed otherwise, disputes between a fund or federation of funds and a medical practitioner concerning their reciprocal obligations, are

within the competence of the arbitration courts set up under the Accident Insurance Act. Instead of the assessors provided for by the Act, four assessors are appointed, two by each of the parties

District Political Authorities

Disputes concerning the payment of contributions and other disputes between employers and insured persons, or between employers and funds, are within the competence of the general political authorities. The decision is taken by or in the name of the head of the administrative authority in question (section 41, subsection 1).

Provincial Political Authorities

Disputes between funds and other public bodies — in particular, hospitals — are finally settled by the provincial governor (section 66).

BULGARIA

ACT OF 6 MARCH 1924

The Bulgarian Act belongs to the group of laws involving a mixed system of special and administrative authorities, and the ordinary courts. According to the nature of the disputes arising out of the administration of sickness insurance, they are referred to:

- (a) Conciliation committees
- (b) The Minister of Commerce, Industry and Labour.
- (c) The ordinary courts.

Conciliation Committees

Composition

The conciliation committees consist of a president chosen from among the local magistrates, a workers' representative, and an employers' representative. The workers' and employers' representatives are elected by secret ballot. The workers' candidates must prove their identity by their insurance books. The employers vote on the basis of the lists on which the elections of members of the chambers of commerce and industry are based. The electors of both classes must have attained the age of 21 years (section 47, subsection 3). The term of office of the elected members is three years (section 47, subsection 4).

Powers

The judicial function of the conciliation committees is to settle disputes concerning benefits in cash and in kind. An appeal against their decisions may be taken to the Minister

Minister of Commerce, Industry and Labour

All disputes other than those concerning benefits are settled in the first instance by the Minister of Commerce, Industry and Labour. The Minister also decides in the second instance any appeals against the decisions of the conciliation committees.

Ordinary Courts

All decisions of the Minister may be appealed against before the ordinary courts.

CHILE**ACT OF 9 SEPTEMBER 1924**

The Compulsory Sickness and Invalidity Insurance Act contains no provision on the nature and powers of the authorities responsible for settling disputes arising out of the administration of insurance. Under section 8 of the Act however, the insurance funds are entitled to the legal privileges granted to poor persons, which suggests that the ordinary judges are competent. The ordinary judicial authorities comprise (1) district judges, (2) sub-delegation judges, (3) ordinary judges.

District Judges

In each district of the Republic an official known as the "district judge" takes cognisance of civil cases in the district involving a sum of not more than 50 pesos.

Sub-Delegation Judges

In every sub-delegation of the Republic there is an official known as the sub-delegation judge, who takes cognisance of

- (a) in the first instance all civil cases involving a sum of 50 to 200 pesos;
- (b) in the second and last instance, appeals against decisions of the district judges.

Ordinary Judges

The ordinary civil judges take cognisance in the first and last instance of all non-contentious cases whatever the value involved, and all civil cases involving sums of over 200 pesos.

They are, moreover, competent to decide, in the second and last instance, in cases which have been brought in the first instance before a sub-delegation judge in the department.

CZECHOSLOVAKIA**ACT OF 9 OCTOBER 1921**

The Czechoslovak Act is in the group of laws involving a mixed system of special authorities, administrative authorities, and the ordinary courts.

The insurance courts (arbitration courts of the sickness insurance institutions, social insurance courts, the Superior Social Insurance Court) are alone competent for all disputes concerning benefits, the rights and powers of insurance institutions, etc. The administrative authorities are responsible for settling disputes arising out of the decisions of insurance institutions with respect to liability to insure, voluntary insurance, the classification of insured persons, etc. Finally, the ordinary courts settle disputes between insurance institutions and employers, and certain disputes between employers and insured persons.

The groups interested — employers and insured persons — sit on the insurance courts as assessors. In practice preponderance is given to professional judges and officials, who occupy the permanent seats.

Arbitration Courts

In each insurance institution an arbitration court must be set up.

The expenses involved in the establishment and working of the arbitration court of an insurance institution are borne by the institution (section 231, subsection 1).

Composition

The arbitration court consists of a president, a certain number of vice-presidents, and 12 assessors (section 198). The president and vice-presidents are

appointed by the president of the ordinary court of first instance within whose area the insurance institution is situated, from among the acting or retired judges (section 199). Six assessors are elected by the general meeting of delegates from among the insured persons, and the remaining six assessors are elected by the employers whose workers are insured in the institution (section 200, subsection 1).

The decisions of the court are taken by a board of three persons (chamber), under the chairmanship of the president or one of the vice-presidents. One of the assessors must belong to the insured persons' group, the other to the employers' group. So far as possible the assessors should belong to the same branch of industry as the plaintiff (section 205, subsection 1).

Powers

The arbitration court has sole competence in respect of complaints against the awards of the insurance institution concerning benefits (section 196).

The parties may appoint authorised representatives to appear before the arbitration court. Any person *sui juris* who is not disqualified from voting at an election of the communal authority may be appointed as an authorised representative. Representation by a lawyer is not allowed (section 207).

Proceedings in the court are public and oral, and the court must give both parties facilities for making a statement on the facts of the dispute. The proceedings may be held in the absence of the parties. The decision is taken by a majority of the votes cast, and the members are bound to vote. The award must be accompanied by the reasons for it, and information respecting appeals (section 208).

An appeal against the award of the arbitration court may be allowed (a) if the court has not taken the evidence offered; (b) if the Act has been contravened in the proceedings or by the award (section 210). The appeal must be lodged with the president of the arbitration court within a fortnight of the communication of the award (section 211, subsection 1). The decision on the appeal is taken by the insurance court.

Insurance Courts

An insurance court must as a rule be established at the seat of each law court of first instance for its area (section 216, subsection 1).

Composition

An insurance court consists of a president, the requisite number of vice-presidents, and 20 assessors. The president and vice-presidents are appointed by the Minister of Justice, in agreement with the Minister of Social Welfare, from among the professional judges exercising their functions at the seat of the insurance court.

Half the assessors are elected by the workers' group and half by the employers' group. The elections are held at the same time and in the same manner as the election of the members of the managing committee of the Central Insurance Institution (section 217).

The judges and assessors of the insurance court are autonomous, like judges of the law courts in the exercise of their judicial functions (section 221).

Powers

The insurance courts have competence to decide on appeals against awards of the arbitration courts of the sickness institutions (section 220, subsection 1 (2)).

Except for disputes concerning benefits, the insurance courts decide on actions for reimbursement under the Act between sickness insurance institutions on the one hand and the bodies which have granted poor relief to an insured person, hospitals, accident, invalidity and old age insurance institutions, or mining benefit societies on the other (section 220, subsection 1 (4)).

The verdict of an insurance court on an appeal against an award of the arbitration court of the sickness insurance institution is final (section 226, subsection 1). Thus, the law established the rule that all disputes must be settled by not more than two instances.

Superior Insurance Court

The Superior Insurance Court is established at Prague for the whole country (section 227, subsection 2).

Composition

The Superior Insurance Court consists of professional judges and employers' and insured persons' assessors. The president, the chairmen of the chambers, and the members of the chambers are appointed from among professional judges by the Minister of Justice, in agreement with the Minister of Social Welfare. The assessors are elected from among employers and insured persons. The elections take place separately (section 217, subsection 3) according to the general regulations for the election of representatives of the parties (sections 200, subsections 2 and 3, 201 to 204, 206, 208, subsection 2, 229).

Powers

Appeals against decisions of the insurance courts in administrative matters concerning which a single judge is competent to decide are settled by the Superior Insurance Court acting through a chamber of three professional judges (section 228, subsection 1).

As a rule the Court decides in private session on the basis of the documents. Oral proceedings may be ordered by the president of the Court. As a rule the Superior Insurance Court issues its decision in the form of a verdict, but if the procedure in the insurance court was so defective that it would be impossible to revise the verdict on the basis of the documents, even if the procedure were completed before the Superior Insurance Court, the latter quashes the verdict of the insurance court and refers the case back to it for a new decision. If the Superior Insurance Court considers that the social insurance court has decided on a matter which is not within its competence, or concerning which an enforceable decision has already been issued or an action is pending in another insurance court, it may quash the verdict (sections 230, subsection 1, and 231, subsections 1 to 3).

The decisions of the Superior Insurance Court are final, so that no appeal can be taken to the Supreme Administrative Court.

The expenses involved in the establishment and working of the insurance courts and of the Superior Insurance Court are borne by the State (section 234 subsection 2).

Administrative Authorities

The administrative authorities decide on all appeals against the decisions of the insurance authorities where decision is not reserved to an arbitration court or insurance court. As already indicated, this excludes disputes concerning benefits (section 196) and disputes concerning reimbursement under the Act between insurance institutions and other public bodies (section 220, subsection 4 (4)).

The decisions of the insurance institutions against which an appeal may be taken to the administrative authorities are those concerning, for instance, the liability to insure, voluntary insurance, the classification of insured persons in wage classes, etc.

An appeal against a decision of a sickness insurance institution may be taken to the district administrative authorities, against whose decision an appeal may be taken further to the regional authorities, and in the last resort to the Ministry of Social Welfare. An appeal against the decision of the Central Social Insurance Institution may be taken to the Ministry, which in this case too is competent in the last resort. No appeal is open against decisions of the second instance confirming those taken in the first instance: that is to say,

when a district administrative authority has decided on an appeal against a decision of a sickness insurance institution and the regional administrative authority confirms the decision, no appeal may be taken to the Ministry (section 239).

Ordinary Courts

Certain disputes to which insurance may give rise cannot be taken to the insurance courts, and are settled by the ordinary courts. This applies particularly to certain disputes between insurance institutions and employers, and certain disputes between employers and insured persons: for instance, disputes between insurance institutions and employers, or between employers and insured persons concerning the deduction of the insured persons' contribution from wages (section 164).

ESTHONIA

ACT OF 23 JUNE 1912

Two systems of jurisdiction for the settlement of disputes arising out of the administration of the Sickness Insurance Act are used. Disputes may be referred either to the ordinary courts or to the sickness insurance supervisory authorities.

The special judicial authorities consist of: (a) the general meeting of the fund; (b) the Workers' Insurance Council; and the ordinary authorities of: (a) the common law courts and (b) the Supreme Court.

Under section 357 of the Industrial Labour Code, according to which the management of a sickness fund must decide as to the existence and duration of a case of sickness, and on the amount of cash benefit to be granted to sick persons, an insured person who may contest the decision taken administratively, can choose between two methods:

- (a) He may protest to the general meeting of the fund (section 358) against the decision and may then appeal against the decision to the workers' insurance authority, the Workers' Insurance Council, and the Supreme Court (administrative chamber).
- (b) He may institute proceedings in the ordinary courts in accordance with the rules for civil procedure.

As a matter of fact, he may begin with the first system and subsequently appeal to the ordinary courts subject to a time limit (one year) (section 266 of the Industrial Code).

General Meeting of the Fund

Composition

The general meeting of the fund consists of representatives of the members (section 86).

Powers

The general meeting decides in the first instance on disputes between the fund and insured persons.

Workers' Insurance Council

Composition

The Workers' Insurance Council, over which the Minister of Labour and Social Welfare, or his representative, presides, consists of the head of the Labour and Social Insurance Department and his deputy, four persons representing respectively the Ministries of Commerce and Industry, Agriculture, Finance, and Justice, one representative of the Superior Health Office, five representatives of persons liable to insurance, and two representatives of employers

The five workers' representatives and their substitutes are elected by a meeting of the delegates of all insurance funds, and the two employers' representatives and their substitutes by the accident insurance associations. Their term of office is three years.

The five workers' representatives are remunerated for their participation in the work of the Council.

Powers

The Workers' Insurance Council is an authority for disputes between funds and insured persons, as well as an authority of the first instance for other disputes.

Ordinary Courts

The ordinary courts have the same powers as those attributed to the Workers' Insurance Council

Supreme Court

The Supreme Court decides in the last resort on disputes arising out of the administration of insurance.

FRANCE

Alsace-Lorraine

SOCIAL INSURANCE CODE OF 19 JULY 1911 AS MAINTAINED BY THE ACT OF 17 OCTOBER 1919

The system of special judicial authorities set up by the 1911 Social Insurance Code is still partially in force. The insurance authorities in Alsace and Lorraine, as in Germany, act as special insurance courts and comprise three instances. They consist of (1) the local insurance offices, (2) the superior social insurance offices and (3) the General Social Insurance Office.

The composition and powers of those insurance offices which have been set up at the seat of each sub-prefecture and in the municipalities of Strasburg, Metz, Mulhouse, Colmar and Guebwiller are the same as in Germany. This applies also to the superior insurance offices at Strasburg, Metz and Mulhouse.

The powers formerly attaching to the Imperial Insurance Office are at present entrusted to the General Social Insurance Office for Alsace and Lorraine at Strasburg, set up by the Decrees of 15 March and 19 April 1919.

Seamen's Insurance

Disputes which may arise out of the administration of the law for protecting seamen in the event of sickness are settled by (a) the commercial courts; (b) the Minister of the Marine; (c) the Council of State.

COMMERCIAL COURTS

Disputes concerning the application of section 22 of the Commercial Code, under which compensation for any sickness occurring during the voyage must be paid by the shipping company or shipowner, are within the competence of the commercial courts.

In districts where there is no commercial court the judges of the civil court exercise the functions and take cognisance of the cases attributed to the commercial judges (Commercial Code, section 640).

THE MINISTER FOR THE MERCANTILE MARINE

Any member of the Provident Fund who contests a decision of the administrator for the area concerning an application for daily benefit may appeal to

the Minister of Marine within a week. The decisions of the Minister on appeals of this kind, as on those concerning the renewed claims for benefit, may be appealed against before the Council of State.

COUNCIL OF STATE

Appeals against the decisions of the Minister must be submitted to the Council of State within two months (Act of 3 April 1900, section 24). Similarly, an appeal against the refusal of the Minister to decide may be taken to the Council of State within four months (Act of 17 July 1900).

The person concerned is entitled to legal assistance.

Miners' Insurance

Under the Act of 28 June 1874, Part III, the ordinary judicial authorities have power to take cognisance of disputes arising out of the administration of insurance. The authorities in question are: (1) the justices of the peace of the Cantons; (2) the ordinary courts; (3) the Council of State.

JUSTICES OF THE PEACE

The local justice of the peace has competence for disputes on the drawing up of lists and the validity of electoral transactions. His decision may be referred to the Court of Cassation (Act of 1894, section 13).

ORDINARY COURTS

The ordinary courts have sole competence to decide all disputes between the fund and its members which affect only individual interests or differences of a private nature, such as those concerning claims on a worker for payment, or the amount of benefit granted him.

The persons concerned are entitled to legal assistance.

COUNCIL OF STATE

In the event of disagreement between the persons concerned with respect to the determination of an area, the decision is taken by a Decree of the Council of State.

A decision of the Minister concerning the rules (approval or non-approval) may be referred to the Council of State (Act of 1894, section 4).

GERMANY

FEDERAL INSURANCE CODE, TEXT OF 15 DECEMBER 1924

The German system is in the group of laws in which special judicial authorities are alone competent.

The insurance offices (judgment chambers and administrative chambers of the public insurance authorities) have in their various degrees (first and second instances and supreme authority), alone competence for all disputes arising out of the administration of the Social Insurance Code, that is to say, they deal with disputes concerning accident and invalidity insurance as well as those arising out of the administration of sickness insurance.

The groups concerned, employers and insured persons, sit on the insurance courts as assessors. In practice preponderance is given to officials and professional judges, who are permanent members of the courts.

The public insurance authorities are:

- (a) the local insurance offices (sections 36-60);
- (b) the superior insurance offices (sections 61-82);
- (c) the Federal Insurance Office and State Insurance Offices (sections 83-109).

These bodies also act as the supervisory authorities for insurance.

Local Insurance Offices

The authority of first instance is the insurance office set up in each administrative district.

Composition

The local insurance offices consist of a president and assessors, but the latter do not take part in administrative procedure, their functions being confined to contentious procedure. In disputes concerning sickness insurance benefits the president, who is an administrative official, may take a preliminary decision. This can be contested and submitted to the judgment committee which consists of three members, one official and two assessors, of whom one is an employer and one an insured person. The assessors are elected by the members of the managing committees of the funds, half from among employers and half from among insured persons. Only Germans who are resident or employed in the district of the local insurance office or who have the headquarters of their undertaking there are eligible.

Powers

In their judicial capacity the local insurance offices take cognisance of disputes concerning sickness insurance benefits (section 1636).

The local insurance office in the district in which the insured person is resident or employed at the time of the application has competence (section 1637).

The president may issue a preliminary decision in any case without oral proceedings (section 1657). The preliminary decision may be contested either by any form of appeal which would be allowed against the principal decision, or by an application, within the same time limit, for oral proceedings. The preliminary decision must mention this possibility and the time limit (section 1658). The proceedings before the judgment chamber of the local insurance office are oral and public (section 1660).

The president decides alone in public oral proceedings concerning sickness insurance benefits in respect of:

- (1) the calculation of duration and amount of sickness benefit;
- (2) the granting of hospital treatment instead of sickness benefit;
- (3) funeral benefit;
- (4) benefits the total value of which does not exceed a sum fixed by the Federal Minister of Labour (section 1661).

Superior Insurance Offices

A superior insurance office is established as a rule for the district of each superior administrative authority.

The Governments of two or more States can establish a general superior insurance office for the whole area or particular parts of their territories. Similarly, superior insurance offices may be established for certain Federal or State departmental undertakings which have their own works sickness funds.

Composition

The composition of the chambers differs according as they are intended for administrative or judicial procedure. When the office acts as a judicial authority the judgment chamber consists of a president, an employer assessor and an insured persons' assessor. If, on the contrary, the decision to be taken is of an administrative character, the chamber consists of two officials of the superior insurance office, one representative of employers and one representative of insured persons. The employer assessors of a superior insurance office are elected by the employer members of the managing committees of the sickness funds; the insured person's assessors are elected on the system of proportional representation by the insured persons' members of the com-

mittees of the funds. In the case of special institutions of the German Federal Railway Company, the supreme administrative authority may rule that the insured persons' assessors shall be elected by the insured persons' representatives on the managing committee of the institution.

Powers

The superior insurance offices decide in disputes on contributions; they act as an authority for appeals against decisions of the local insurance offices concerning sickness benefits. In the event of disputes on elections a decision of the superior insurance office (administrative chamber) is final. For appeals in sickness insurance cases, the superior insurance office for the district of the local insurance office which issued the contested decision has competence (section 1676).

The appeal must be lodged with the local insurance office, which forwards it to the superior insurance office with the preliminary proceedings not more than a fortnight later (section 1680).

The appeal effects a stay if it concerns (1) the resumption of curative treatment, (2) commutation for a lump sum (section 1682).

The assessors are summoned to take part in the proceedings of the judgment chamber in order of rotation fixed in advance (section 1684).

If a superior insurance office wishes to dissent from an officially published decision of the Federal Insurance Office involving a question of principle in a case in which review or final appeal is not allowed, or if a question arise in any such case respecting a hitherto unconfirmed interpretation of legal provisions of fundamental importance, the superior insurance office must refer the case to the Federal Insurance Office with a statement of its reasons (section 1693).

A review of the decisions of the judgment chamber of a superior insurance office is allowed in sickness insurance cases (section 1694) except in certain matters in which no appeal is allowed against the decision of the superior insurance office, namely, decisions concerning:

- (1) the amount of cash benefit, family allowance, or funeral benefit;
- (2) the payment of an allowance to a sick person who was not incapable of work or was incapable for less than eight weeks;
- (3) maternity benefit;
- (4) family benefits;
- (5) commutation for a lump sum;
- (6) costs of proceedings (section 1695)

Federal Insurance Office and State Insurance Offices

The Federal Insurance Office is the supreme judicial authority. It has competence throughout Germany, except in certain States (Baden, Bavaria, Saxony) where State insurance offices are still in existence, their functions being the same as those of the Federal Insurance Offices.

Composition

The Federal Insurance Office consists of permanent and temporary members (section 85).

The president and other permanent members are appointed for life by the President of the Republic, on the recommendation of the Federal Council. The President of the Republic appoints the directors and presidents of the Chambers from among the permanent members. The Federal Minister of Labour appoints the other officials (section 86).

There are 32 temporary members, of whom 8 are appointed by the Federal Council including at least 6 from among its own members; 12 are elected as representatives of employers and 12 as representatives of insured persons (section 87). Members of accident insurance associations who are entitled to vote, their legal representatives, the managers of their establishments who hold powers of attorney, and the officials of establishments for which an

executive authority has been appointed are eligible as employers (section 93). Persons insured against industrial accidents and insured persons members of the committee of an insurance institution are eligible as insured persons (section 94)

The Federal Insurance Office takes its decisions as a Chamber. In its judicial capacity the Chamber consists of a president, who is a professional judge, another a judge in the judicial or administrative system; a permanent member of the Office, and two temporary members representing employers and insured persons respectively (section 98)

When the Federal Insurance Office acts as an administrative authority, the Administrative Chamber consists of a president, a director or chairman of the Chamber, a temporary member elected by the Federal Council, a permanent member, and two assessors, one of whom is chosen from among employers' representatives and the other from among insured persons' representatives (section 100)

With a view to securing uniformity of practice a High Commission is set up in the Federal Insurance Office which consists of a president, two members elected by the Federal Council, two permanent members, two judicial officers, two employers and two insured persons (section 101). It acts when a Chamber of the Federal Insurance Office takes a different view from that of another Chamber which has previously taken cognisance of a similar question.

Powers

The Federal Insurance Office takes cognisance of insurance disputes as the supreme judgment and administrative authority (section 83). The State Insurance Offices which were established before the Act of 15 December 1924 came into force for the territory of a Federal State may remain in existence so long as there are at least four superior insurance offices under their jurisdiction. They have the same powers as the Federal Insurance Office.

An appeal against a decision taken in the first instance by a superior insurance office must be lodged with the Federal Insurance Office or a State Insurance Office (section 1793). The authority responsible for deciding on appeal may stay the execution of the contested decision (section 1794).

GREAT BRITAIN

ACT OF 7 AUGUST 1924

The British system belongs to the group of laws involving both special authorities and the ordinary courts.

The special judicial authorities (referees, arbitration committees, insurance committees) act when the rules of the approved societies provide for the settlement of disputes by arbitration in cases concerning insurance benefits or in disputes between insurance institutions and medical practitioners or dispensing chemists.

Administrative jurisdiction is within the competence of the Minister of Health, but it should be pointed out that the powers of the Minister are not limited to purely administrative questions. He is entitled to settle disputes between insured persons and insurance institutions, as also between different institutions, whether approved societies or not.

The High Court of Justice is the final court of appeal against decisions of the Minister of Health in the matter of liability to insurance.

Referees and Arbitration Committees

Composition

In the event of a dispute between an insurance institution and insured persons, the institution appoints a referee. The insured person may demand

the appointment of an arbitration committee of three members, one appointed by the institution, one by himself, and the third by agreement between the two first or by lot¹.

Powers

The referees and arbitration committees decide in the first instance any disputes concerning insurance benefits. Their decisions are not final and an appeal may be taken to the Minister of Health, who appoints a new referee; the decision of the latter is final.

Insurance Committees

Composition

The insurance committees are local institutions consisting of 20 to 40 members and comprising several sub-committees. The representation of the various interests is as follows: three-fifths of the members represent insured persons: one-fifth are appointed by the county council: the remaining members are appointed by the local medical committee and the Minister, the numbers varying according to the size of the committee.

Powers

Insurance committees are set up to administer medical benefit and to deal with complaints by insured persons and disputes between approved societies, medical practitioners and dispensing chemists. An appeal against their decisions may be taken to the Minister of Health, whose decision is final.

Minister of Health

The Minister of Health has competence if any question arises:

- (a) whether any employment or class of employment is or will be employment within the meaning of the Act, or whether a person is or was employed within the meaning of the Act or is entitled to become a voluntary contributor;
- (b) as to the rate of contributions payable by or in respect of any insured person;
- (c) as to the rates of contributions payable in respect of a compulsorily insured person by the employer and the insured person respectively;
- (d) as to the person who is or was the employer of a compulsorily insured person.

If, however, any person is aggrieved by the decision of the Minister on any question arising under pars. (a) or (d) above, he may appeal therefrom on any question of law to a judge of the High Court selected for the purpose by the Lord Chancellor, and the decision of that judge is final.

The Minister may, on new facts being brought to his notice, revise any decision given by him, other than a decision against which an appeal is pending or in respect of which the time for appealing has not expired. An appeal lies against any such revised decision in the same manner as against an original decision (section 89, subsections 1 and 2).

Every dispute between an approved society and an insured person; an approved society and any person who has ceased to be a member for the purposes of the Act of the society; an approved society and any of its branches; any two or more branches of an approved society; as also every dispute between an approved society and any person as to whether that person is or was at any date a member of the society for the purposes of the Act, is decided in accordance with the rules of the society, but any party to such dispute, may in such cases and in such manner as may be prescribed, appeal from the decision to the Minister.

¹ In practice there are two systems of jurisdiction: that of referee and that of an arbitration committee. It may be added, however, that, according to the model rules adopted by most approved societies, the system most of them used is that of the referee.

Every dispute between (a) an insured person and an insurance committee; (b) two or more approved societies; (c) an approved society and an insurance committee; (d) two or more insurance committees, is decided in the prescribed manner by the Minister.

Subject to the provisions of the Act the Minister may authorise the referees appointed by him to decide an appeal or dispute submitted to him under section 90 of the Act.

Regulations may be made providing for the procedure of any such appeal or dispute, and such regulations may apply any of the provisions of the 1889 Arbitration Act. Any decision given by the Minister or the referee in these disputes is final and conclusive (section 90).

In certain matters of a judicial nature the powers and duties of the Minister are exercised by him through a special body or special bodies of persons (section 91).

High Court of Justice

Decisions of the Minister on questions of liability to insurance which involve a question of law may be taken in the second and last instance to the High Court of Justice.

GREECE

ACT OF 8 DECEMBER 1923

Disputes arising out of the administration of the Compulsory Insurance Act are referred to the ordinary courts.

HUNGARY

ACTS No. XIX OF 1907 AND XXXI OF 1921

The Hungarian system belongs to the group of laws in which special judicial authorities are alone competent.

The special authorities (special insurance courts, Superior Insurance Court) have competence in all disputes which may arise out of the administration of the Sickness Insurance Act. The parties concerned are represented by assessors.

Special Insurance Courts

Composition

When the insurance courts of first instance, of which there are 34, excluding the courts for the mining funds, decide in disputes on benefits, the members sit in boards of three persons, the president being a professional judge and the assessors chosen one from among employers and the other from among insured persons. All other disputes concerning sickness insurance are settled by the professional judge alone.

The assessors in the insurance courts of first instance are elected by the employers and insured persons in the general meeting of the district funds in equal numbers by secret vote and in accordance with the principles of proportional representation. In the mining funds and the mutual benefit funds the election is conducted in the same manner. The assessors are chosen by the president of the court from among employers and insured persons, account being taken of the trade involved in the case.

When the court has to decide on the loss of working capacity of an insured person it must consult a medical expert.

Powers

The judicial authorities of the first instance have competence for all disputes connected with sickness insurance, subject to one exception — disputes

concerning the dietary of insured persons treated in public hospitals or hospitals considered as such are within the competence of the administrative authorities and in the last resort of the Administrative Court, in accordance with section 47 of Act No. XXVI of 1896.

Superior Insurance Court

Composition

The Superior Insurance Court takes its decisions in a board of five judges in cases of appeals against the decisions of a court of first instance sitting in a board of three judges. The board of five judges consists of the president (president or director of the Superior Insurance Court), two professional judges, and two assessors representing employers and insured persons respectively. In disputes which have been settled in the first instance by one judge only, the Superior Insurance Court decides in a board of three members who are professional judges.

In questions of principle on which different judicial decisions have been taken either by the Superior Insurance Court or by the courts of first instance, the Superior Court may decide in a full session of all its members. Such decisions bind the courts until a plenary decision to the contrary has been taken. In the case of decisions in which assessors have taken part, the full session includes, in addition to the president and the judges of the Superior Insurance Court, assessors representing employers and insured persons in equal numbers.

In the Superior Insurance Court any decision on a medical question is taken by a special medical chamber, of which the president, vice-president and members are appointed by the Minister of Justice, in agreement with the Minister of Social Affairs and Labour, from among university professors, directors of hospitals, or medical practitioners with similar qualifications.

Powers

The Superior Insurance Court is the supreme authority for all disputes arising out of the administration of sickness insurance.

IRISH FREE STATE

ACT OF 16 DECEMBER 1911

The Irish Free State belongs to the group of countries with a mixed system of special authorities, the ordinary courts and administrative authorities.

The special judicial authorities (referees or arbitration committees) take cognisance of disputes concerning insurance benefits. The administrative authorities (Insurance Commissioners) and the ordinary courts (Supreme Court judges) are the authorities of last instance.

The parties concerned are represented on the arbitration committees.

Arbitration Courts

Composition

Most disputes are referred to an arbitration court consisting of three members, one of whom is appointed by the insurance institution, one by the insured person, and the third by agreement between the representatives of the two parties. In other cases, disputes are settled by a referee elected by the general meeting of the insurance institution.

Power.

The arbitration courts act as the authorities of first instance for disputes concerning insurance benefits. Decisions of the referees or arbitration courts are not final, but an appeal may be taken to the Irish Insurance Commissioners, whose decision is final.

*Irish Insurance Commission**Composition*

The members of the Commission are appointed by the Minister for Local Government and Public Health. At present the Commission consists of three members, namely, a president, a medical practitioner, and a woman.

Powers

The Insurance Commission decides in the first instance on all disputes concerning liability to insure, the classification of insured persons, contributions and employers' obligations. Its decision is final if the dispute is only on a question of fact. If, on the contrary, a point of law has to be decided, an appeal against the decision must be taken to the Supreme Court of Appeal, which appoints a judge.

The Commission takes cognisance in the second instance of appeals against the decisions of the arbitration courts.

Judges in the Supreme Court of Appeal

An appeal against decisions taken by the Irish Insurance Commission in the first instance on questions of liability to insurance may be admitted on questions of law. In this case the Supreme Court appoints a judge from among its members whose decision is final.

ITALY (New Provinces)

LEGISLATIVE DECREE OF 26 DECEMBER 1925;

ACT OF 30 DECEMBER 1923

The legislation for the new provinces places Italy in the group of countries with special and administrative judicial authorities.

The special judicial authorities (arbitration committee, Central Arbitration Committee) take cognisance respectively in the first and last insurance of disputes arising out of the administration of compulsory insurance. The administrative authorities settle any disputes between sickness funds and the arbitration authorities of an administrative nature.

The parties concerned (employers, medical practitioners, and insured persons) are represented on the committees.

*Arbitration Committees**Composition*

Each arbitration committee consists of:

- (a) a president, who is a judge appointed by the Minister of Justice and Ecclesiastical Affairs,
- (b) two representatives of employers, one of whom is chosen from industry, the other from agriculture, and two representatives of insured persons, one of whom is chosen from industry and the other from agriculture, appointed by the Prefect after consulting the respective local organisations (employers and insured persons);
- (c) two medical practitioners if the dispute concerns the determination of invalidity.

The permanent members of the committee and their substitutes are appointed by the Minister of National Economy.

Powers

The arbitration committees set up by the Act of 30 December 1923 are authorities of first and last instance to settle disputes arising out of compulsory invalidity and old-age insurance. The extension of this system to the new

provinces made it possible to include within the competence of these committees disputes arising out of the administration of the provincial sickness insurance system.

Central Arbitration Committee

Composition

The Committee consists of:

- (1) one councillor of the Court of Cassation, who is *ex-officio* president, appointed by the Minister of Justice and Ecclesiastical Affairs;
- (2) two legal experts;
- (3) two medical practitioners with special scientific and professional qualifications, who intervene only if the dispute relates to the determination of invalidity;
- (4) two representatives of employers and two representatives of insured persons.

The members of the committee are appointed by the Minister of National Economy in agreement with the Minister of Finance.

Powers

The Central Arbitration Committee takes cognisance of disputes arising out of the administration of invalidity and old-age insurance and the provisional sickness insurance system, in cases of incorrect procedure.

JAPAN

ACT OF 22 APRIL 1922; IMPERIAL ORDER OF 30 JUNE 1926

The Japanese system is in the group of laws setting up special and administrative judicial authorities.

The insurance courts of the various degrees (special insurance courts of the first and second instance, the Central Insurance Court) have alone competence for all disputes arising out of the administration of the Act except those within the competence of the administrative authorities.

The parties concerned, employers and insured persons, sit on the insurance courts as members in equal numbers. The other members of the courts are persons with scientific qualifications or recognised experience, and the president is a higher official appointed by the Minister for Home Affairs. These courts may therefore be regarded as joint institutions.

Insurance Courts of First Instance

There are 50 courts of first instance, set up one in each prefecture.

Composition

They consist of:

- (a) a president;
- (b) two or three members with scientific qualifications and recognised experience;
- (c) two or three members representing employers;
- (d) two or three members representing insured persons.

The president is appointed by the Cabinet on the recommendation of the Minister of the Interior. The members are appointed by the Minister of the Interior.

Powers

These courts settle disputes concerning insurance benefits.

*Insurance Courts of Second Instance**Composition*

These courts consist of:

- (a) a president;
- (b) three members with scientific qualifications or recognised experience;
- (c) three members representing employers,
- (d) three members representing insured persons (section 106 of the Order).

The president is appointed by the Cabinet on the recommendation of the Minister for Home Affairs from among the higher officials of his Department. The members are appointed by the Cabinet (section 108 of the Order).

Powers

These courts take cognisance of appeals against decisions of the authority of first instance

*Central Insurance Court**Composition*

The Central Insurance Court consists of a president and 15 members, of whom five each are chosen from among experts, employers' representatives and insured persons' representatives.

The president of the Central Insurance Court (third instance) is the Director of the Social Affairs Office (section 105 of the Order). The members are appointed by the Cabinet on the recommendation of the Minister of the Interior.

Powers

The Central Insurance Court is the supreme judicial authority for all disputes arising out of the administration of the Act except those for which the administrative authorities are competent.

Administrative Authorities

Disputes concerning contributions are not within the competence of the special insurance courts, but are settled by the Director of the Department for Social Affairs, whose decision may be contested before the Minister for Home Affairs or the Administrative Court.

LITHUANIA

ACT OF 9 DECEMBER 1923 PROMULGATED ON 27 MAY 1926 AND AMENDED ON 28 SEPTEMBER 1926

The institutions responsible for settling disputes concerning the administration of sickness insurance are in the group of special judicial authorities. Arbitration committees have competence to settle disputes between insured persons and the authorities of the funds, and conciliation committees deal with disputes between the funds and members of the medical profession.

The Superior Insurance Office is the supreme authority for all disputes arising out of the administration of the Sickness Insurance Act.

The persons concerned, employers, insured persons and medical practitioners, are represented on these bodies.

*Arbitration Committees**Composition*

The arbitration committees consist of five members, two of whom are chosen by the meeting of the fund from among representatives of insured persons and two from among representatives of employers, and the fifth is appointed by an absolute majority of the other four members (section 158).

Powers

The arbitration committees settle disputes between insured persons and the managing committees concerning benefits. An appeal against their decisions may be taken to the Superior Social Insurance Office whose decision is final (section 161).

*Conciliation Committees**Composition*

A conciliation committee consists of an equal number of representatives of the managing committee of the fund and medical practitioners, with a president chosen from outside these two groups (section 163).

Powers

The conciliation committees are set up in each district and decide in the first instance on disputes between the funds and members of the medical profession (section 162). An appeal against their decisions may be taken to the Superior Social Insurance Office, whose decision is final.

*Superior Social Insurance Office**Composition*

This Office was originally to consist of two representatives of the Ministry of the Interior, two representatives of insured persons and one representative of employers.

During the session of 9 July 1926 the Seimas passed the third reading of an amendment replacing the second representative of the Ministry of the Interior by a representative of organisations of the medical profession.

Powers

The Superior Social Insurance Office is the supreme judicial authority for disputes arising out of the administration of the Act.

It has competence:

- (a) to decide on the validity of the decisions of the general meeting of a fund against which an appeal may be taken in a fortnight either by the labour inspector or by any other person concerned (section 118);
- (b) to dismiss members of the managing committee who contravene the provisions of the law or rules of the fund, and institute proceedings against them in the courts (section 130);
- (c) to decide on the validity of the decisions of the managing committee against which an appeal may be made within a week (section 152);
- (d) to decide disputes between the Federation of Funds and the managing committee of a particular fund (section 174).

LUXEMBURG**ACT OF 17 DECEMBER 1925**

Luxemburg is in the group of countries with a system of special authorities: ordinary courts and administrative authorities.

In the first instance, the Central Committee of the supervisory authorities settles disputes concerning the scope of the funds, and disputes between funds, employers and insured persons.

In the second and last instance these cases may be taken before the arbitration courts. The Government itself settles disputes between the funds and other public bodies. Finally, supreme authority is to the Council of State.

The persons concerned are directly represented on the Central Committee of the supervisory authorities.

*Central Committee of the Supervisory Authorities**Composition*

The Central Committee consists of officials and salaried employees appointed by the Government. The members are assisted in their work by representatives of the funds (employers and insured persons) (text of 26 March 1926; memorandum of 30 March 1926).

Powers

The Central Committee, or its assessors, settles disputes between sickness funds concerning the affiliation of particular undertakings. An appeal against decisions of the Central Committee or its representatives on this point may be taken to the Government.

The Central Committee and its assessors also decide in the first instance on all disputes between insured persons and employers, or between persons who are, have been, or wish to be insured. It also decides disputes between employers and funds concerning the calculation, apportionment or payment of contributions, the benefits to be granted and the affiliation of members.

On all these points the decisions of the Central Committee or its assessors may be contested before the arbitration courts, whose decisions are final (section 79).

*Arbitration Courts**Composition*

The headquarters, competence and organisation of the arbitration courts are defined by public administrative regulations, which must also lay down the rules of procedure before these courts.

Powers

The arbitration courts settle in the second and last instance all disputes which have not been settled by the Central Committee or its assessors.

An appeal to quash the decisions taken in the last resort by the arbitration courts may be made by both parties in cases of contravention of the law or incorrect procedure (section 294).

The Government

Disputes between sickness funds, on the one hand, and accident insurance associations, old-age and invalidity institutions, communes or charitable institutions, on the other, are settled by the Government.

The Judgment Chamber in the Council of State

An appeal to the Council of State (judgment chamber) may be taken against a decision of the Government within one month of the date of the decision.

NORWAY**ACT OF 6 AUGUST 1915**

The Norwegian system belongs to the group of laws in which special judicial authorities are alone competent.

Only the courts set up for the purpose (committees of three, the State Insurance Institution, the State Insurance Appeal Commission) have competence for all disputes arising out of the administration of the Insurance Act. The persons concerned are directly represented on all these authorities.

*Committees of Three**Composition*

Each committee is elected for a term of three years by the communal authorities for the locality in which the sickness fund is situated. It consists of a member of the communal council, an employer and a member of the district sickness fund. The committee elects its own president, who may be given remuneration on the decision of the communal council. Persons who have served on the committee for three years may refuse to accept re-election for the next three years (section 66, subsection 1).

Powers

These committees decide in the first instance on all disputes connected with sickness insurance except those for which the State Insurance Institution has competence.

*State Insurance Institution**Powers*

This Institution has competence for all disputes which may arise between district sickness funds, respecting claims and obligations arising out of the administration of the Act, and disputes between a district sickness fund and the commune concerned as regards the obligations of the commune towards the fund. It also acts as the appeal authority for decisions of the committees of three.

Any application for a dispute to be settled by the Institution must be lodged in writing at latest on the twenty-eight day after the party contesting the decision was informed of it (section 67, subsections 1 and 2).

*State Insurance Appeal Commission**Composition*

The State Insurance Appeal Commission consists of seven members, namely: a professional judge as president, a medical practitioner and a social insurance expert appointed by the Government; two representatives of employers and two representatives of insured persons elected for a term of three years by the Storting. In particular cases the commission may co-opt experts.

Powers

This Commission is an authority for appeals against decisions of the State Insurance Institution. Within 28 days any decision to refuse to approve a sickness fund or to withdraw approval or any dispute between a district sickness fund or approved fund and the State Insurance Institution on matters in which the fund concerned has a substantial interest, may be referred to the Commission (section 68, subsection 1).

If on the pretext that a person is not insured against sickness the district fund refuses benefit for an industrial accident which comes under the Workers' Accident Insurance Act, the case may be referred on the application of any party interested to the State Insurance Appeal Commission (section 66, subsection 4).

POLAND**ACT OF 19 MAY 1920**

The Polish system belongs to the group of laws with special and administrative authorities.

On the one hand arbitration committees settle disputes concerning benefits and contraventions of the rules of the funds and, on the other, conciliation committees settle those arising between the medical profession and their organisations and the funds. In the last instance all disputes arising out of the

administration of the Act come within the competence of the judicial authorities of the Central Insurance Office (administrative authority).

On all these bodies the parties concerned, employers, insured persons and medical practitioners, are represented in equal numbers.

Arbitration Committees

An arbitration committee is set up in each sickness fund

Composition

Each committee consists of five members elected for one year by the delegate meeting of the fund, two of whom are elected by the insured persons' representatives and two by the employers' representatives. The fifth member is elected by the whole delegate meeting by simple majority.

Powers

The arbitration committees settle all disputes concerning benefits and decide on the fines to be imposed on members of the fund for malingering or for contravention of the regulations for persons (section 83).

The decisions of the committees are final.

Conciliation Committees

The regional insurance offices set up conciliation committees in the area of each fund.

Composition

Each conciliation committee consists of an equal number of representatives of medical practitioners and of the managing committee of the fund. One of the representatives of medical practitioners is appointed by the professional organisation, the remainder are elected by all the medical practitioners of the fund from among themselves. The two groups of the conciliation committee choose a president by common agreement, or, failing agreement, the president is appointed by the regional insurance office (section 84).

Powers

Disputes between the managing committee of a sickness fund and medical practitioners of their organisations are within the competence of the conciliation committee.

An appeal against the decision of the conciliation committee may be taken to the judicial authorities of the Central Insurance Office.

Judicial Authorities in the Central Insurance Office

An appeal against decisions of the managing committees of the funds concerning the liability to insure, the payment of contributions, the classification of insured persons in wage classes, or the apportionment of contributions between employers and insured persons, may be taken to the judicial authorities of the Central Insurance Office.

When the Central Insurance Office decides on such cases it must comprise representatives of insured persons and employers in equal numbers. Until special judicial authorities have been attached to the regional social insurance offices civil proceedings are taken.

PORTUGAL

ACT OF 10 MAY 1919

The Portuguese system belongs to the group of laws in which special judicial authorities are alone competent

All disputes arising out of the administration of sickness insurance legislation must be settled by the arbitration courts set up for each insurance and

social welfare district. In its judicial capacity the Superior Social Welfare Council takes cognisance of the appeals and cases referred to it.

The parties concerned are represented in these institutions.

Arbitration Courts

An arbitration court must be set up for each social insurance and public welfare district (section 60).

Composition

An arbitration court consists of a president, four members and four substitutes. The head of the social insurance district acts as president. Three members of the court must be chosen from among representatives of mutual benefit societies and one from among local members of the medical profession. In no case may representatives of the sickness funds belong to an arbitration court (Decree No. 5636, section 60, subsections 1-3).

Powers

The arbitration courts decide on

- (1) complaints of the decisions of compulsory or voluntary social insurance institutions;
- (2) disputes concerning the interpretation of the rules of a fund or a federation of funds situated within the area of the court;
- (3) complaints concerning the exclusion of insured persons;
- (4) disputes concerning benefits and the liability to insure.

Proceedings before the courts are free of charge, but the costs are met by the losing party in case of vexatious proceedings (Decree No. 5636, section 61).

Superior Social Welfare Council

Composition

The Superior Social Welfare Council is presided over by the Minister of Labour. The vice-president is the Director-General of the Institute of Social Insurance and Public Welfare. The Council further includes:

- 4 members appointed by the administration council of the Institute of Social Insurance and Public Welfare;
- 1 professor of the Superior Commercial Institute (insurance theory);
- 1 professor in the Faculty of Law of Lisbon University;
- 3 representatives of compulsory mutual benefit institutions for sickness insurance, elected by district;
- 2 representatives of voluntary mutual benefit institutions, elected by the associations;
- 2 representatives of workers' organisations and 2 representatives of employers' organisations;
- the Director of the Mutual Benefit Societies; the social welfare inspector.

Representatives of the sickness funds cannot belong to the Superior Social Welfare Council (section 44 of the Regulations).

Powers

In its judicial capacity the Superior Council takes cognisance of all the cases referred to it.

ROUMANIA

ACTS OF 25 JANUARY 1912, 30 MARCH 1888, AND NO. XIX OF 1907

The Roumanian system belongs to the group of laws with special and administrative authorities and the ordinary courts.

The special authorities (arbitration courts) take cognisance of all disputes between employers or sickness funds and insured persons, as also of disputes

concerning benefits. The administrative authorities (administrative council of the Central Insurance Office) are the supreme authority for appeals against decisions of the special authorities. All disputes between insurance institutions and third parties must be taken to the ordinary courts.

The parties concerned are represented in the special institutions.

Arbitration Courts

An authority of first instance, the arbitration court, is set up in each district.

Composition

Each arbitration court consists of the president of the ordinary court or his representative, a worker assessor, and an employer assessor. The worker is chosen by lot from a list drawn up by the general meeting of the guilds. The employer is chosen by lot from a list drawn up by the chamber of commerce. The assessors must be of Roumanian nationality and not less than 25 years of age.

Powers

The arbitration courts have competence to settle all disputes between employers and insured persons, between sickness funds and insured persons, and disputes concerning insurance benefits or the payment of contributions.

Administrative Council of the Central Insurance Office

An appeal against decisions of the arbitration courts may be taken to the administrative council of the Central Insurance Office, whose decision is final.

Ordinary Law Courts

The arbitration courts and the administrative council of the Central Insurance Office have not sole competence for disputes concerning sickness insurance. Any dispute between a third party and the State sickness funds or the guilds or the Central Insurance Office is within the competence of the ordinary courts (sections 227-229).

RUSSIA

ACT OF 9 NOVEMBER 1922

In Russia all insurance disputes are referred to administrative authorities.

The administrative authorities (audit committees, provincial insurance authorities, principal insurance departments) take cognisance of disputes concerning benefits (complaints by employers or insured persons).

The parties are represented through the medium of the trade union and inter-trade union organisations.

Committees of Funds

Composition

Its composition may vary, but there must be at least three members elected by the inter-trade union conference.

Powers

The committee receive all complaints by insured persons concerning benefits.

*Provincial Insurance Authorities**Composition*

The members of the provincial insurance authorities are elected by the inter-trade union congress or appointed by agreement between the social insurance authorities in the Commissariat of Labour and the inter-trade union authorities.

Powers

These authorities decide on complaints of insured persons in the second instance and of employers in the first instance.

Principal Insurance Departments

A principal insurance department is set up by each of the Federal Republics.

Composition

The members of the principal department are appointed by agreement between the Commissariat of Labour and the Trade Union Council for the Republic.

Powers

The department is the authority of second instance for disputes between insurance institutions and employers.

Labour Courts

A labour court is constituted by the people's court sitting in a special session for disputes connected with labour.

Composition

It consists of a president appointed by the provincial court and two members, one of whom represents the Superior Council of National Economy and the councils of national economy of the governments and the other the Trade Union Council.

Powers

The labour court takes cognisance of appeals of employers against awards for attachment given by the insurance authorities.

Supreme Court

The Supreme Court (ordinary judicial authorities) may, on the application of the Commissariat of Labour, cancel the decisions of the courts which have already been carried into effect.

SERB-CROAT-SLOVENE KINGDOM

ACT OF 14 MAY 1922

The Yugoslav system belongs to the group of laws with special and administrative authorities.

The special authorities (insurance courts and the Superior Insurance Court) settle disputes between insured persons and their dependants on the one hand and the administrative bodies of the funds on the other. The administrative authorities settle disputes between employers and insured persons concerning contributions.

The parties concerned are represented on the insurance courts.

Insurance Courts

These authorities of first instance are set up for each local workers' insurance institution.

Composition

Each court consists of a president and not less than 20 assessors (section 161, subsection 1). The president is appointed by the Minister of Justice from among judges of the courts of first instance or superior courts carrying on their activities in the headquarters district of the insurance court (section 161, subsection 2).

The assessors are elected by the general meeting of the insurance institution for a term of three years by employers and insured persons separately in such a way that the various branches of production are represented in due proportion (section 161, subsection 3). The assessors are deemed to be public servants during their term of office (section 161, subsection 6). They must be nationals of the Serb-Croat-Slovene Kingdom and not less than 30 years of age (section 163, subsection 1). In order that the worker assessors may be able to attend the meetings of the court the Act lays down that their employers must grant them facilities for the discharge of their duties. Any pay lost in consequence of their duties in the court must be repaid out of the Central Workers' Insurance Institution (section 164, subsection 2).

The court acts through a committee of five persons consisting of the president, who must be a professional judge, two assessors chosen by employers and two assessors chosen by insured persons. The president calls upon the assessors in the first instance from the trade to which the parties belong or a related trade, in the order fixed in advance annually (section 165, subsection 2).

Powers

The insurance courts have competence for disputes between insured persons or their dependants and the insurance institutions concerning the benefits or compensation due from the latter (section 160, subsection 2).

Superior Workers' Insurance Court

This appeal authority has its seat at that of the Central Workers' Insurance Institution.

Composition

The Superior Workers' Insurance Court consists of a president and not less than four permanent members who must all be professional judges. It is not competent to adopt decisions unless the president and at least two members are present (sections 172-174).

Powers

The Superior Workers' Insurance Court has competence to take cognisance of appeals against decisions of the courts of first instance.

Administrative Authorities

Disputes arising out of the administration of insurance, such as disputes between employers and insured persons concerning contributions, are settled by the administrative authorities acting in a judicial capacity. These authorities decide in the first instance and an appeal against their decision may be taken within a week to the Minister of Social Affairs, whose decision is final (section 159, subsection 2).

SWITZERLAND

ACT OF 13 JUNE 1911

In Switzerland the authorities are either special judicial authorities or the ordinary courts, according to the Canton.

General Principles

In principle the fundamental Act of 13 June 1911 on sickness insurance (Part 1) recognises the competence of the ordinary courts to settle disputes between a fund and another fund, insured persons, or third parties. Provisions to the contrary may, however, be adopted by cantonal law or the rules of the funds, in the latter case only with respect to disputes between the fund and its members. A Canton may, for instance, reserve the settlement of these disputes to the police court, similarly the rules may make the general meeting competent to settle disputes between the fund and its members.

According to the information published by the Federal Department of National Economy¹, of the Cantons which have introduced compulsory insurance, those of Appenzell (Inner and Outer Rhodes) have set up special judicial authorities; those of Basle Town and St. Gall have adopted a mixed system of the ordinary courts and administrative authorities.

Before describing the organisation of the authorities in these four Cantons it may be stated generally that as the cantonal laws and orders on compulsory insurance are based on the Federal Act, disputes between the funds and insured persons concerning benefits or affecting a principle established by federal law may always be referred by administrative proceedings to the Federal Social Insurance Office representing the Federal Council.

Appenzell, Inner Rhodes

ORDER OF 29 NOVEMBER 1920

For the settlement of disputes arising out of the administration of compulsory sickness insurance special committees have been set up for each of the two public funds.

Special Insurance Committees

Composition

Each of these committees consists of seven members, namely, one member for each districts, except for the district of Appenzell, which is represented by two members, and representatives of compulsorily insured persons.

Powers

The committees decide on disputes between a fund and another fund or an insured person or third parties. Their decisions on disputes between funds and insured persons or third parties may be appealed against to the Council of State.

Appenzell, Outer Rhodes

ORDER OF 30 APRIL 1916: TEXT OF 30 MAY 1924

The system of jurisdiction is very similar to that described for Appenzell, Inner Rhodes; it comprises special insurance committees with the right of appeal to the Council of State against their decisions.

¹ Volkswirtschaft, Arbeitsrecht und Sozialversicherung der Schweiz. Vol 11, p. 911

*Special Insurance Committees**Composition*

The special insurance committees set up to settle disputes arising out of the administration of insurance are established on a communal basis and must include representatives of the communal councils and insured persons (in particular compulsorily insured persons).

Powers

These committees decide on all disputes arising out of the Act, the cantonal order or the rules of the fund. They have competence to impose a fine for any failure to observe the liability to insure. The first appeal authority for decisions of the special committees concerning disputes is the communal council. The supreme authority is the Council of State.

Basle Town

ACT OF 12 MARCH 1914, AMENDED BY THE ACTS OF 10 OCTOBER 1918 AND
23 FEBRUARY 1922

An appeal against decisions of the manager of the public fund may be taken to the Department of Health within a fortnight of the date of the decision. The decisions of the Department of Health may in turn be referred to the Council of State, and those of the Council of State to the administrative court, within the limits defined by cantonal law

St. Gall

ACT OF 28 MAY 1914

Disputes are taken to the president of the district, except those arising between funds, which are settled directly by the Council of State. The president of the district thus acts as the authority of first instance for all disputes arising out of the right or obligation to join a fund, as well as those concerning benefits. An appeal against his decision may be taken to the Council of State.

CHAPTER III

OFFENCES AND PENALTIES

The complete working of compulsory insurance involves the provision of penalties for infringements of the law.

Penalties are generally imposed by the ordinary courts; it is much easier to adapt criminal courts to matters arising out of insurance than civil courts. They may also be imposed by the insurance institutions themselves or by special insurance courts.

In this part of the Report the simplest method of summarising the situation seemed to be to enumerate the principal types of offences, state the penalties provided for them and mention the judicial authorities by whom they are imposed.

§ 1. — Offences

The following are the commonest offences in connection with compulsory sickness insurance laws, and for which penalties have been prescribed.

ENFORCEMENT

The penalties provided under this head apply to employers who, without adequate reason, fail to submit the required declaration within the time allowed or furnish incorrect information concerning their personnel. They apply also to persons who do not carry out, or incompletely carry out, their obligation to compile, keep and submit lists of workers, deduct from the wages of their personnel amounts higher than the legal rate, or make deductions from wages on the pretext of insurance from persons who are not entitled to receive benefit.

DELAY IN PAYMENT OF THE EMPLOYERS' CONTRIBUTION

The penalties laid down to compel employers to pay insurance contributions regularly together with the amount of the deductions made from wages apply equally when the management neglects to place the proper stamps on the insurance cards or books, or illegally withhold the worker's receipt card or insurance book.

ILLICIT BENEFITS

The suppression of frauds and offences committed by insured persons in order to obtain by illegal methods benefits to which they are not entitled or benefits higher than those to which they are entitled, is dealt with by provisions which may involve the suspension of all or part of the cash benefits for a definite period. These provisions also apply to insured persons who are guilty of malingering, neglect medical instructions, fail to observe the regulations laid down for insured persons during sickness or knowingly make false statements or reports.

FRAUD AND FALSIFICATION OF DOCUMENTS

Under this head are classified infringements consisting in the forging or falsification of stamps or other insurance forms, for the purpose of evading financial obligations connected with insurance obtaining illicit benefits or embezzling funds.

In addition to fine and imprisonment the laws of some countries provide for the loss of civil rights in case of conviction of such offences.

IRREGULARITIES IN ADMINISTRATION

Members, officials or employees of insurance institutions are also liable to penalties for violation of professional secrecy, retaining in the office insurance accounts which should be submitted for audit, neglect of legal requirements and irregularities or false declarations for the purpose of fraudulently obtaining subsidies.

OBSTRUCTION

The laws of certain countries, especially Germany and Great Britain, provide severe penalties for persons who obstruct the supervision of the enforcement of the law by refusing to furnish information or documents which they are required to submit to the authorities or their delegates, by preventing an insured person from giving evidence before an inspector or by obstructing or attempting to obstruct workers holding official positions in supervisory or judicial organisations connected with social insurance.

§ 2. — Penalties

According to the seriousness of the offence, the delinquent is liable to imprisonment, loss of civil rights or fine, or may be compelled

to pay arrears of contributions, sometimes with the addition of a sum equal to or greater than the amount owed. He may also be removed from official positions in insurance institutions.

The penalty of imprisonment applies only to particularly serious cases, such as the falsification of documents for criminal purposes, violation of professional secrecy or deliberate misrepresentation of the financial position of an insurance fund for the purpose of procuring illicit subsidies or assistance of any kind.

According to the seriousness of the offence, such infringements may involve, in addition to imprisonment, the loss of civil rights or the payment of a fine.

Any delegate who breaks the law or neglects his duties may be removed from an official position in insurance institutions.

The penalty of a fine is provided for infringements committed by representatives of insurance organisations in the exercise of their duties, e.g. maladministration of the funds, neglect of the rules or legal provisions, obstruction of inspectors. Fines are also provided for offences committed by employers and by insured persons, in case of neglect of medical instructions, false declarations concerning sickness, etc. The laws of certain countries also provide that employers or insured persons who do not pay their contributions regularly may be required to pay the arrears with the addition of a penalty, the amount of which is fixed by the competent authorities.

§ 3. — Judicial Authorities

Penalties may be imposed by the ordinary courts, the local, district or central administrative authorities, special insurance courts or the insurance institutions themselves.

As a general rule, the ordinary courts take cognisance of all offences involving penalties fixed by the Penal Code or the Code of Criminal Procedure. They take cognisance of all infringements of insurance laws only in countries which have no special insurance courts. The local, district or central administrative authorities generally take cognisance of infringements committed by insurance organisation, e.g. funds, mutual-aid societies, insurance companies, etc. They often hear appeals from the decisions of the special courts.

The special insurance courts are generally competent to deal with all offences committed by insured persons or employers. They deal with offences connected with the payment of benefits, the sharing of contributions, communication of documents and information, reports of sickness, etc.

In some States the insurance organisations themselves are competent to impose the penalties provided for neglect of the legal provisions regulating the relations between the funds, employers and insured persons.

In a few laws the competent courts are not stated: the legal texts merely enumerate the offences and penalties without expressly stating the authorities competent to impose each penalty. In such cases the competence is determined by the ordinary rules of procedure according to the amount of the fine or the penalty to be imposed.

ORDINARY COURTS

The ordinary courts (county courts, courts of summary jurisdiction, and police courts) are competent to take cognisance of offences coming within the provisions of the Penal Code. Some States, which have no special insurance courts have left the ordinary courts to deal with all infringements of the laws and regulations concerning sickness insurance. This is the case in Chile, Greece, the new provinces of Italy and the Cantons of Basle Town and St. Gall in Switzerland. In other States the ordinary courts hear only appeals from the decisions of the administrative authorities; this is the case in Bulgaria, Czechoslovakia, Portugal, and the Serb-Croat-Slovene Kingdom. In Great Britain and Ireland the courts of summary jurisdiction deal with offences regarding the payment of contributions and kindred matters, and the High Court of Justice hears appeals from the decision of the administrative authorities on questions of liability to insurance.

ADMINISTRATIVE AUTHORITIES

Certain States have given the administrative authorities power to impose the penalties provided for infringements of the insurance laws and regulations. This is the case in Austria and Bulgaria. In the latter country infringements are reported by the factory inspectors and penalties imposed by the Minister of Commerce, Industry and Labour; appeals to the ordinary courts are permitted only if the amount of the penalty imposed exceeds a fixed sum (300 levas).

In Switzerland, the Federal Council and, by delegation of powers, the Federal Social Insurance Office have jurisdiction over insurance funds which fail to comply with the provisions of the law. In the Serb-Croat-Slovene Kingdom all infringements of the regulations

governing the administration of funds, i.e. the insurance organisations and their officials, are within the competence of the Minister of Social Welfare. In Czechoslovakia offences outside the competence of ordinary courts are dealt with by the Supreme Administrative Court.

SPECIAL INSURANCE COURTS

It is quite clear that the special courts cannot take cognisance of infringements of a criminal nature, which are reserved for the ordinary courts; they deal especially with infringements in administration, such as failure to observe the insurance regulations, neglect of payment of contributions, etc. This is the case in Germany, Lithuania, Luxemburg, Norway, Poland, Portugal, Roumania, the Serb-Croat-Slovene Kingdom, and the two Cantons of Appenzell in Switzerland.

INSURANCE FUNDS

Certain States have empowered the funds to impose certain penalties themselves. Their competence extends to cases of incorrect statements and reports, negligence in complying with the rules and failure to observe medical instructions.

The right to impose penalties has been granted to insurance institutions in Austria, Germany, Great Britain, Irish Free State, Luxemburg, Norway, and Russia.

§ 4. — Analysis of National Legislation concerning Infringements and Penalties

Having briefly indicated the types of infringement, the nature of the penalties and the method of imposing them and the competent authorities, we shall now proceed to analyse the legislation of the different countries, showing the penalties provided for offences committed by members of the insurance institutions, employers, insured persons, physicians, and other legal persons.

AUSTRIA

ACT OF 30 MARCH 1888. TEXT OF 20 NOVEMBER 1922

The penalties imposed on persons guilty of infringements of the legal provisions concerning sickness insurance in Austria are indicated below.

Officials

Officials of the funds who contravene the provisions of the law or the regulations are liable to fine or detention.

Employers

Any employer who refuses to submit to the insurance institutions information concerning the insured persons employed by him or who refuses to make the statements required by insurance institutions, is liable to a fine (sections 67 and 70). The fine may be changed to imprisonment when the employer deliberately withholds from the wages of the insured person contributions exceeding the amount laid down in the regulations (section 68).

Insured Persons

Any insured person who, by pretence or false statement, acts to the prejudice of the insurance fund is liable to a fine.

BULGARIA

ACT OF 6 MARCH 1924

Infringements of the laws concerning compulsory sickness insurance are subject to penalties, especially in the case of employers who neglect or refuse to undertake the obligations imposed on them by the Act and by doctors.

Employers

Offences are reported by the factory inspectors and other supervisory authorities; the statement of the case is submitted to the Minister of Commerce, Industry and Labour, countersigned by the supervisory authorities and the delinquents and constitute proof of the offence in default of contrary evidence. The Minister is responsible for imposing fines, the maximum being 250 levas for insured persons and 5,000 levas for employers; in cases of repetition of the offence the fine may be increased up to 10,000 levas. The imposition of a fine does not preclude the possibility of legal prosecution (section 49, par. 1).

The statement of the case must include, for the purpose of determining the amount of the fine or the period of imprisonment, the extent, commercial position and turnover of the undertaking and must also mention whether the delinquent has observed the provisions of other laws for the protection of workers.

Fines imposed by the Minister and not exceeding 300 levas are not subject to appeal, fines exceeding that amount may, in accordance with the Criminal Procedure Code, Chapter V, be contested in the ordinary courts.

Doctors

Offences by doctors are reported by the medical inspectors. The statement of the case, countersigned by both parties, must be submitted to the Superior Medical Council. The Minister of Commerce, Industry and Labour on the advice of the Council may impose a fine (section 49, par. 2).

All fines are collected in the same way as direct taxes (section 50, par. 2).

CHILE

ACT OF 8 SEPTEMBER 1924

The Chilean Act provides that an employer who fails to enter the names of his compulsorily insured workers is liable to a fine. This applies also to small merchants and manufacturers who, after warning by a police official, factory inspector or employee of the insurance department, fails to enter his name directly.

An employer or insured person who fails to pay his contributions is liable to a fine equivalent to 25 times the amount of the unpaid contribution.

Appeals against fines imposed on delinquents are permitted only if the amount of the fine has first been paid to the State Treasury and the appeal is presented within five days by summary procedure before the judge on duty in the civil court.

Collection of arrears of contributions and fines imposed by way of penalties takes place through the local fund, the decisions of which have executive authority.

CZECHOSLOVAKIA

ACT OF 9 OCTOBER 1924

Any physical or legal persons who are guilty of offences are liable to the following punishments provided that their act does not involve any more severe penalty.

Officials

Officials of insurance organisations who violate professional secrecy are liable to a fine not exceeding 5 000 crowns (section 260 (c))

Employers

A fine not exceeding 5,000 crowns, according to the seriousness of the offence and the amount of damage caused, may be imposed on employers who, without sufficient excuse, fail to carry out the obligation of making the required declaration or make an incorrect declaration, fail to keep lists of employees as required, deduct a contribution exceeding that authorised by the Act or attempt to restrict the rights of the insured person (section 260, (a), (b), (c), (d))

Insured Persons

Insured persons who have fraudulently obtained insurance benefits or failed to comply with other obligations imposed by the Act are liable to a fine (section 260 (g)).

Penalties are imposed by the administrative authorities of first instance. An appeal may be made to the authorities of second instance and, in special cases, to the Supreme Administrative Court

If the fine cannot be collected, it may be commuted to imprisonment. Fines are handed over to the sickness insurance institution, which uses them for extraordinary benefits in favour of insured persons who have exhausted their right to benefit

ESTHONIA

ACT OF 23 FEBRUARY 1912

When the Act of 1912 came into force, penalties were provided in the Penal Code for infringements of the provisions of the Insurance Act

Officials

Any person who knowingly grants assistance from the insurance funds to persons not entitled thereto, not belonging to the fund, or to their relatives, is liable to imprisonment for not less than three months and not more than one year.

The same penalty is provided for persons who knowingly agree to the use of money or other property of the fund for purposes other than those provided for in the regulations. If the amount of assistance granted or sums expended exceeds 30 000 Estonian marks, the delinquent is liable to the loss of all civil rights and privileges and is also liable to imprisonment for not less than one year and not more than three years. When the offence has been committed inadvertently and the loss involved is voluntarily made good the penalty is commuted to imprisonment for not more than three months

Employers

Infringements of the provisions concerning the communication of information of the work done in undertakings, the number of persons employed, the amount of wages, the date of payment, the date of engagement of workers and the date of resignation or dismissal, or of the provisions concerning the submission of documents, accounts, registers and statistics provided for by the Act of 1912, are punished by a fine not exceeding 10,000 Estonian marks for the first offence and 20,000 Estonian marks for subsequent offences.

The communication of false information is punishable by a fine of not more than 100,000 Esthonian marks or two to four months' imprisonment.

The employment of women at paid labour within four weeks of confinement, when such women are members of a sickness insurance fund, is punishable by a fine of not more than 10,000 Esthonian marks or imprisonment for not more than one month.

Insured and Other Persons

The factory inspectors are instructed to prosecute any person guilty of infringement of the provisions of the Workers' Sickness Insurance Act.

GERMANY

ACT OF 19 JULY 1911 • TEXT OF 15 DECEMBER 1924

Penalties

Criminal penalties are determined by the Penal Code, the Code of Criminal Procedure and the Act concerning the organisation of the courts. The amounts derived from the payment of fines revert to the National Treasury.

All other penalties, whether of the nature of an injunction, coercion or accessory penalties, are determined by the Insurance Code, which at the same time mentions the authorities competent to impose them.

Members of Insurance Funds and Offices, and Officials or Employees of Such Institutions

Any member, official, or representative of an insurance institution or authority who violates professional secrecy by revealing without authorisation facts concerning diseases, their causes or origins, is liable to a fine or imprisonment for not more than three months. Prosecutions are undertaken only at the request of insurance institutions or the supervisory authorities.

Any official or expert of an insurance institution who violates a manufacturing secret or divulges any fact calculated to injure the commercial interest of an undertaking, is liable to the same penalty. When the offence has been committed with the object of injuring the undertaking or of deriving pecuniary advantage therefrom, the penalty may be imprisonment and may be supplemented by the loss of civil rights and a fine (section 142).

When the offence is committed by an official responsible to the State or a communal authority, the above penalties are replaced by the penalties provided in the civil service regulations.

Employers and Managers

Fines may be imposed by the insurance authorities on employers for false or incorrect statements or for failing to supply the information prescribed (section 1487). The same penalty is provided for employers who do not use the insurance stamps within the period laid down, or fail to pay their contributions. Such fines are recovered in the same manner as the local rates and taxes (section 1488).

A disciplinary fine is provided for persons who fail to report workers coming within the insurance scheme (section 1489).

The same provisions apply to members of the board of directors of an incorporated company, mutual insurance society, co-operative association, guild or other body corporate, the manager of a limited liability company, the shareholders personally responsible when the employer is any other kind of commercial company, and the legal representatives or liquidators of an undertaking (section 1493).

In case of delegation of responsibility by the employer, delegates who are guilty of offences are liable to the same penalties, the employer being still liable if he has been aware of the offence or has failed to take the necessary precautions in the selection and supervision of the delegates. The delegates may also be condemned to pay a sum equal to double the arrears of contributions (section 1494).

Employers and insurance institutions are forbidden to obstruct insured persons in the exercise of official duties connected with the Federal insurance system or to discriminate against them by reason of their holding such positions, or the manner of their exercising such functions. Employers and their representatives are also forbidden to obstruct either in whole, or in part, by arrangements or works regulations, to the prejudice of the insured persons, the enforcement of legal provisions concerning social insurance (section 139). An offence of this kind involves penalties of fine or detention unless more severe penalties are provided elsewhere.

Insured Persons

Insured persons who fraudulently claim from the employer sums higher than those due to them for the same period or who claim their whole quota from more than one employer, or who do not use the money received by them for the payment of their contributions, are liable to fine or detention unless a more severe penalty is provided elsewhere (section 1491).

Falsification of Documents

Any person who makes false entries on receipt forms or falsifies the information shown on a printed form or knowingly uses a false document, may be prosecuted. A prosecution for forgery may not be undertaken unless the falsification was committed for the purpose of obtaining personal advantages or causing prejudice to other persons (section 1495).

Any person who forges, uses, sells or puts in circulation stamps to be used as genuine, is liable to imprisonment which may involve the loss of civil rights (section 1496).

The same penalty may be imposed in case of the use, sale or circulation of stamps already used; in cases where there are extenuating circumstances the imprisonment shall be commuted to detention or fine (section 1497).

Persons reproducing without written authority dies, seals, engravings, plates or other articles used in the manufacture of stamps, are liable to fine or detention (section 1499).

The superior insurance office (judgment chamber) is the final and supreme authority to hear appeals from penal decisions of directors of insurance institutions or offices.

GREAT BRITAIN

ACT OF 7 AUGUST 1924

Prosecutions for infringements of the provisions of the Act are dealt with in sections 96, 97, 98, 99 of Chapter 4 of the Act of 7 August 1924.

Insurance Organisations

Negligence or delay in the communication of information required by the competent authorities or maladministration of the fund may involve withdrawal of approval from the fund. In such cases the usual practice is for the business of the fund to be transferred to another fund.

Employers

Any employer who does not pay the contributions, or deducts or attempts to deduct from the wages or other remuneration of a person compulsorily insured, the whole or a part of the employer's contribution, or who is guilty of other infringement of the Act, or failure to comply with its requirements, is liable to a fine not exceeding £10 for each offence on summary conviction, and where the offence is failure or neglect on the part of the employer to pay any contributions he may be required to pay to the Minister a sum equal to the amount of the contributions not regularly paid (section 96, subsection 2).

Any employer who has failed or neglected to pay a contribution which he is required to pay on account of a worker employed by him, or who has not conformed or has failed to conform, in respect of that worker, with the requirements of the regulations concerning the payment and collection of contributions, provided that such omission prevents the worker or any person acting in his name from receiving in whole or in part the benefits to which he would have been entitled, is liable to be sued summarily by the employee who has suffered by the omission, negligence or refusal of the employer as for a civil debt, for a sum equal to the amount of the monetary benefits forfeited and also for a sum equal to the amount of the expenses incurred through the fact that the employee was not entitled to medical assistance (section 98, subsection 1)

Insured Persons

If an insured person is guilty of any contravention of or non-compliance with the requirements of the Act or regulations, he is liable on summary conviction to a fine not exceeding £10, and if, in order to obtain a benefit or a payment to which he is not entitled, an insured person knowingly makes a false declaration or false report, or is guilty of any other infringement of the Act, he is liable on summary conviction to imprisonment for not more than three months with or without hard labour or to a fine not exceeding £3.

Other Legal Persons

Any legal person who carries on without due authorisation trade in insurance cards or books or used insurance stamps is liable on summary conviction to a fine not exceeding £20; any person who obstructs the supervision of the enforcement of the Act by refusing information required, refusing to submit documents required by the Act, or preventing the questioning of persons summoned by an inspector is liable to a fine not exceeding £5 (section 96, subsections 3-4).

GREECE

ACT No. 2868 OF 19 NOVEMBER AND 8 DECEMBER 1923

Any employer who neglects or refuses to establish social insurance for his employees to the extent to which he is required to do so, is liable to a fine of 2,000 drachmae for each month of delay; the amount of the fine reverts to the workers' insurance fund.

The recovery of this sum is within the competence of the Minister of National Economy (Act No. 551, section 6 (d)).

IRISH FREE STATE

ACT OF 16 DECEMBER 1911

The penalties provided for infringements of the Act apply to members of the administrative organisations, employers and insured persons.

Officials

Negligence or delay in the communication of information required by the competent authorities, or maladministration of the fund, generally involves withdrawal of approval from the fund. In such cases the business of the fund is transferred to another fund.

The communication of false or inadequate information and frauds and falsification of accounts render liable to a fine of not more than £50.

Employers

Refusal to pay contributions or delay payment, or obstruction of the investigations of the inspector on the part of employers constitutes an offence subject to a fine not exceeding £10. If the infringement involves an insured person in the loss of all or part of his rights to benefit, the employer is required to make good the amount of the loss incurred by the insured person.

Insured Persons

The communication of false information or inaccurate declarations for the purpose of obtaining benefits is subject to the suspension of benefits or expulsion from the fund, enforced by the board of directors of the fund, or to imprisonment for not more than three months (section 69).

LITHUANIA

ACTS OF 9 DECEMBER 1925 AND 28 SEPTEMBER 1926

Infringements of the Compulsory Sickness Insurance Act involve the following penalties for employers and insured persons.

Employers

Employers who fail to notify the fund of the engagement of a worker who should be compulsorily insured, deduct from the wages of workers an amount higher than that which they should pay as insurance premiums, or neglect or refuse to deduct from the wages of their workers the necessary premium, are liable to a fine not exceeding 500 litas.

Refusal to communicate to the insurance institutions the necessary information may be punished by a fine not exceeding 400 litas (sections 176, 177).

Insured Persons

Any insured person who neglects or refuses to follow medical instructions or is guilty of malingering is liable to a fine which may amount to ten times as much as the daily sickness benefit (section 175).

Penalties are imposed by the Superior Social Insurance Office.

LUXEMBURG

ACT OF 17 DECEMBER 1925

The following penalties may be imposed on persons guilty of infringements of the Sickness Insurance Act.

Officials

Officials of sickness funds are responsible under ordinary law for the execution of their duties and for failure to carry them out (section 298).

A fine may be imposed on members of sickness funds who, without legitimate cause, refuse or neglect to carry out their duty or fail to attend meetings regularly.

Any breach of the provision concerning professional secrecy is subject to penalties provided by section 458 of the Penal Code (section 314).

Employers

Managers of undertakings and employers who do not carry out their obligations in the matter of insurance, or are slow in carrying them out, or are slow or inaccurate in communicating the information required, are liable to a fine not exceeding 500 francs. The same fine may be imposed on employers who do not pay their full contributions.

A fine of from 51 to 1,000 francs, without prejudice to further prosecution under another law or regulation, is provided for managers or employers or their deputies who by agreements or works regulations knowingly interfere with the total or partial enforcement of the Act, to the detriment of insured persons, or restrict the freedom of the latter to hold official positions. A similar penalty is provided for persons who make deductions not authorised by the Act from the wages of insured persons, or fail to hand over the sums deducted by them from the wages of their employees (section 312).

Insured Persons

Any insured person who is guilty of an infringement of the regulations governing sickness or the instructions of the physician attending him, or neglects to inform the sickness fund of the amount of benefits which he is simultaneously receiving from another fund, or fails or delays to carry out the obligations imposed on him by the Act, may be punished by a fine equal to three times the amount of the daily sickness benefit.

Other Persons

Any persons who induce the insurance institution to provide benefits or other advantages to which they are not entitled, or only partially entitled, are liable to imprisonment or fine. The delinquent may also be put under police supervision for a period of from two to five years and deprived of all or part of their rights for a period of from five to ten years (section 315).

All fines may be imposed by the board of directors of the fund. An appeal may be made to the central committee (section 80). The amount of the fines imposed under the Act goes to the funds of the organisation whose committee imposes them (section 311).

NORWAY

ACT OF 6 AUGUST 1915

The Sickness Insurance Act provides for penalties for offences by employers, insured persons and members of the medical profession.

Employers

Any employer who neglects to deduct from the payment of wages the contribution due from the insured person must himself pay that contribution, and will not be entitled to reimbursement if the worker has left his service or if three months have expired since the payment in question. Interest is charged at the rate of 6 per cent. on arrears of contributions. More severe penalties are imposed on employers who neglect to submit statements or to communicate the information required by the Act, or give incorrect information as to the conditions of work and wages of their employees, the date of their engagement or dismissal, or the date of beginning work (section 74).

Insured Persons

Duly authorised funds may recover in the same way as taxes or any other public contributions, premium contributions which are due in respect of compulsory or voluntary insurance. Such recovery takes place at the request of the committee of the insurance fund through the medium of the officials responsible for recovering taxes (section 71 (3)).

Doctors

Doctors, dentists and midwives who neglect to furnish accounts and certificates required by the Act are liable to fine.

Public prosecutions may only be undertaken at the request of the local fund involved, or by the Royal Insurance Office (section 74 (3)).

POLAND

ACT OF 19 MAY 1920

The following penalties are provided by legislation for infringements of the provisions of the Insurance Act by employers and insured persons

Employers

Any employer who neglects to enter the names of his workers on the lists of insured persons is liable for the payment of all contributions beginning from the date of engagement; a fine may be imposed equal to five times the amount of arrears of contributions (section 16)

A fine not exceeding 100 zlotys and, in cases of deliberate infringement, 300 zlotys (section 95, subsection 1) may be imposed on employers for any infringement of the obligation to communicate to the fund notice of the engagement of persons coming under the compulsory insurance scheme, and for the deduction from wages of sums greater than those fixed by the Act.

Any other infringement of the regulations relative to the entering of the names of insured persons is subject to a fine not exceeding 20 zlotys (section 95, subsection 2).

Insured Persons

Infringements of the regulations laid down for sick persons may be punished by a fine amounting to not more than five times the daily sickness benefits (section 94).

All penalties are imposed by the insurance office at the proposal of the director.

PORTUGAL

ACT OF 10 MAY 1919

Infringements of the Act are subject to the penalties provided in Chapter VII of Decree No. 5636 of 10 May 1919.

Officials

Members of the management of mutual insurance societies who have failed to carry out their obligations in submitting documents to the director-general of social insurance services and keeping special books as laid down by the Government, or have neglected their duty, are liable to a fine of 5 to 20 escudos each, the fine may be doubled in case of repetition of the offence (section 54).

Apart from measures personally affecting the administrators of the fund, the social insurance institute may order, without the possibility of appeal, any reform necessary to restore the proper working of the service and safeguard the rights of insured persons (section 63).

Refusal on the part of the officials of the fund to submit the documents of the society to the delegates of the institute involves penalties provided by the Penal Code (section 64).

Employers

Any employer who neglects or refuses to keep in order insurance books is required to pay a fine equivalent to 100 times the amount of the sum due for the first offence, 300 times the amount of the sum due for subsequent offences. If the offence is repeated, the employer may be brought before the courts for disobedience of the Act at the application of the social insurance institute to the Public Prosecutor (section 67).

Insured Persons

Insured persons who neglect to pay their contributions lose the right to cash benefits for the first illness. Unpaid contributions are deducted from wages. In case of false declaration either at the time of entry or during illness, insured persons lose the right to half the benefits due for the first illness.

Fines may be imposed by the arbitration courts for social welfare (section 66). Infringements under the Penal Code are dealt with by the ordinary courts.

ROUMANIA

ACT OF 26 JANUARY 1912

The following disciplinary measures and penalties are provided for infringements of the Act of 1912.

Officials

In cases of irregularities or abuses in administration the Central Office immediately dismisses the delinquent officials, while safeguarding the organisation as a whole. Penal prosecutions may also be undertaken against persons who have embezzled funds belonging to the organisation.

Employers

Any employer who fails to affix the contribution stamps is liable to a fine of from 10 to 100 times the amount of the stamps which he has omitted to affix, the fine may be doubled in case of repetition of the offence

Insured Persons

Frauds on the part of insured persons with reference to contributions due are subject to a fine of from 20 to 200 times the amount of the stamps.

Fines imposed by the Central Office or by a decision of a committee of arbitration, recovered in accordance with the Act concerning the recovery of State contributions.

RUSSIA

ACT OF 9 NOVEMBER 1922

Penalties for infringement of the legal provisions respecting social insurance are prescribed by section 133 of the Penal Code, which according to the gravity of the offence imposes imprisonment or hard labour up to one year or a fine up to 10,000 roubles.

Officials

Delay in opening insurance accounts or falsification of books may be punished by disciplinary penalties. In case of repetition of the offence the court may impose compulsory labour for not less than three months. A maximum of three months' imprisonment or a fine not exceeding 30 roubles may be imposed in case of communication of false information.

Employers

Delay in the payment of insurance contributions may lead to confiscation by administrative order. The order for confiscation applies first to the sums owed to the delinquent by third parties including State institutions, secondly to current accounts of the delinquent in credit institutions and, finally, to the real and personal estate of the delinquent.

A delay of more than three months in the payment of insurance contributions, refusal to enter the names of persons employed in the insurance and the communication of false information are subject to prosecution. The penalties involved are a fine of not less than 100 roubles or imprisonment for not more than one year

Insured Persons

The legal provisions concerning penalties on the part of insured persons prescribe in certain cases loss of cash benefits and measures to prevent malingering. Penalties imposed by funds on insured persons guilty of malingering may apply separately or simultaneously to the amount of the benefits and the period of sick leave allowed. The same penalties may be imposed on persons who fail to follow medical instruction or to attend for medical consultation.

An appeal may be made by the insured person against the imposition of penalties; appeals are heard by the provincial social insurance authorities.

SERB-CROAT-SLOVENE KINGDOM

ACT OF 14 MAY 1922

The acts regarded as infringements and the penalties provided are shown below. At the end will be found information as to the authorities competent to impose penalties

Officials

Responsible officials of autonomous organisations who fail to comply with the laws and regulations are liable to a fine of not more than 600 dinars (section 145 (2))

Employers

Any employer who fails to report the engagement or departure of employees coming under the insurance scheme, states their wages as more or less than the actual amount, connives at any act to the prejudice of the insurance institution, prevents his workers from acting as assessors of insurance courts or as members of insurance institutions, enters into illegal agreements with his workers or makes deductions higher than those authorised by the Act, fails to pay the insurance contributions when they are due or to keep lists of employees in accordance with the Act, is liable to a fine (sections 194, 195 (1), 196 (1), (2), 197 (1), (5)).

Insured Persons

Any insured person who has fraudulently obtained benefits by malingering is liable to a fine (section 195 (2)).

Fines imposed on employers and insured persons vary from 5 to 5,000 dinars according to the seriousness of the offence. They are imposed by the police authorities on the application of the insurance institutions; an appeal may be made from these decisions to the court of first instance or the district court.

Fines are imposed on insurance organisations by the Minister of Social Welfare or the Board of Directors of the Suzor, and are handed over to the Suzor, which uses them for the payment of extraordinary benefits to pensioned persons.

SWITZERLAND**FEDERAL ACT OF 13 JUNE 1911**

The provisions of the Federal Act concerning insurance refer exclusively to infringements by insurance funds and their officials. The penalties are disciplinary and penal.

*Insurance Organisations**Disciplinary Measures*

The Federal Council may, of its own accord or after summary hearing of an accusation, impose a fine of not more than 100 francs on any fund which contravenes the general conditions of recognition by the Federal Government, uses its funds for objects not connected with insurance or fails to balance its accounts once a year and submit them to the Federal Council. The Council may also withdraw recognition in case of persistent infringement, and must do so in the case of any fund which ceases to extend to its members the necessary security, or fails to take the steps required by the authorities for recovering its financial equilibrium.

Penal Sanctions

The representatives of a fund who, in their accounts or in other information submitted to the Federal authorities, deliberately misrepresent the situation of the fund, are liable to a fine not exceeding 500 francs or imprisonment for not more than three months; these penalties are cumulative, and may be doubled in case of repetition of the offence.

Prosecution takes place on the application of the Federal Council, and is undertaken by the cantonal authorities. The Federal Council may have recourse to an appeal against such decisions in accordance with Articles 158 and following of the Act of 22 March 1893 on the organisation of the Federal courts.

CANTONAL ACTS

Appenzell (Outer Rhodes)*Order of 30 April 1916 Text of 30 May 1924***Appenzell (Inner Rhodes)***Act of 30 April 1916 (Text of 30 May 1921); Order of 29 November 1920*

Without prejudice to the provisions of the Federal Act, the arbitration committees are competent to impose on insured persons the penalties provided for infringement of the provisions of the cantonal Acts concerning compulsory sickness insurance.

Basle Town*Act of 19 November 1914***St. Gall***Act of 6 July 1914*

Without prejudice to the provisions of the Federal Act, penalties may be imposed on insured persons by the ordinary courts.

PART VI

THE POSITION OF FOREIGN WORKERS

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INTRODUCTION

In view of the nature and aims of sickness insurance, equality of treatment for national and foreign workers is seen to be a necessary condition if the insurance is to be completely effective in protecting both individuals and the community. By giving the worker a means of restoring his health as quickly and as economically as possible, sickness insurance lessens the chances of disablement or premature death, protects society against the risks of infection, ensures the maintenance of productive power and is, in general, of as much importance to the community as to the individual. Now, sickness insurance covers a permanent and immediate risk, to which the foreign worker is just as much exposed as the national worker, and this risk may occur however short the stay of the foreign worker in the country where insurance is compulsory.

A foreign worker who falls ill cannot on grounds of humanity be deprived of a minimum of care, and if he is excluded from the insurance system he will become a public burden until his cure or repatriation. Often, however, the precarious situation of a worker employed abroad, the need of earning a livelihood for a necessitous family, and the difficulty of obtaining medical assistance delay the indispensable treatment. It becomes more difficult to cure him, and the period during which he is deprived of his earnings by incapacity to work is lengthened. Sometimes, when faced with the results of being without pay, he will return to work before he is cured, the risks of infection being thus increased as well as those of aggravation of the illness, disablement, or death. The absence of treatment at the right time thus interferes with the prophylactic purpose and social effects of insurance.

Moreover, the burden of any relief in the form of medical attendance and the like incurred in respect of an uninsured foreign worker who falls ill or is disabled is usually borne altogether by the country of residence, and there is no possible means of demanding a contribution from the worker. If, on the contrary, the risk of sickness is covered by insurance, the contribution which the insured person must pay reduces in a certain proportion the share of the community in the cost of medical treatment.

Quite apart from the risk itself and its consequences, the exclusion of foreign workers from the scope of compulsory insurance has a deleterious effect on the employment of national workers, for whom insurance is compulsory. The foreign worker, not being obliged to pay contributions, is able to accept a lower wage than that demanded by a worker who knows that a sum will be deducted from his wages for purposes of insurance, and if the employer himself is exempt from paying a contribution in respect of the foreign worker he employs, the tendency to give preference to the latter will be strengthened.

Even if foreign workers are excluded from insurance, it is possible, of course, to require employers to pay the same contribution for all their workers — national and foreign — but it is not possible to demand the payment of contributions from workers who are not entitled to benefit. Thus the exclusion of foreign workers exempts them from a burden imposed on national labour and creates dangerous competition in the labour market by giving foreigners the power to accept lower wages as a means of obtaining preference from employers.

It is therefore in the interests of the body of workers covered by insurance to admit foreigners, and such admission would seem to entail equality of treatment in the event of illness. A foreigner who is required to share in the costs of insurance to the same extent as nationals has the right to claim an equal share in the benefits payable if the event insured against occurs. As a matter of fact, most laws grant complete equality of treatment to foreign and national workers, at least with respect to the conditions of obtaining benefits and the actual benefits.

The exceptions to the rule of equality of treatment are generally limited in scope. Some seem based solely on the desire to avoid the administrative complications arising out of the position of foreigners employed in frontier districts or inland navigation, account being taken of the special conditions which the insurance of such classes

of workers should fulfil. The laws allowing these exceptions usually make provision for changing the system in force for foreign workers of this class by way of diplomatic agreements and subject to the condition of reciprocity.

Other exceptions are based on political considerations. They define the treatment of a foreigner in accordance with the position of nationals in his State of origin. Thus he may be entirely deprived of the protection organised by the law, or have the right to certain benefits only in so far as reciprocity is established by diplomatic agreement or even without special agreement.

Finally, the law sometimes gives the executive authorities power to extend or limit the rights and privileges granted to foreign workers according as the country of origin of the worker itself adopts a similar attitude.

The system of equality, which is the general rule in respect of affiliation and benefits, becomes, on the contrary, the exception when it is a question of the part played by foreigners in the administration of insurance. The participation of the insured in the management of the institutions to which they are affiliated and the application of insurance laws may take the form either of appointing the persons responsible for managing the funds or institutions, or of carrying out the duties that may be assigned to them in the various organs of management and supervision or in the special courts responsible for settling disputes arising out of the administration of social insurance. Foreigners may be given the same right as nationals to elect the persons representing them in the administration of the funds, but as a rule they are not themselves eligible for administrative or supervisory functions or for the special judicial institutions. The usual view of the law is that the duties entrusted to insured persons in the bodies responsible for assisting in the administration of the law are public duties to be reserved for nationals.

No special provisions are necessary with respect to the contributions of foreign workers and the financial systems in force for covering the risks they bear. Consequently the only points on which the position of foreigners call for remark are those relating to: (1) admission to insurance, (2) the rights to benefits, and (3) participation in management.

§ 1. -- Admission to Insurance

None of the laws exempt foreigners from insurance. Nevertheless, the right of retaliation sometimes reserved to the executive authorities may subject the full equality of treatment generally established to a possible and conditional limitation. In some countries the position of foreign workers staying temporarily on their territory is subject to special regulations. Finally, one law makes the admission of certain classes of foreign workers dependent on a guarantee of reciprocity in the matter of the right to work for nationals living in the countries of origin of the foreign workers.

COMPLETE EQUALITY

No formal conditions are imposed here limiting the admission of foreigners to insurance on the same conditions as nationals. The laws enumerated below establish full equality, whether the admission of foreigners on the same conditions as nationals is explicitly prescribed in the Act, or whether the definition of the workers covered is such that it includes foreigners: Austria, Bulgaria, Chile, Esthonia, France (miners), Hungary, Lithuania, Luxemburg, Portugal, Russia, and Switzerland (Appenzell, Basle Town, and St. Gall).

The laws of Great Britain and Northern Ireland and of the Irish Free State provide for equality of treatment. They do indeed also empower the Minister to issue special rules concerning the application of sickness insurance to foreigners, but hitherto no use has been made of this faculty.

COMPLETE EQUALITY SUBJECT TO THE POSSIBILITY OF RETALIATION

Certain laws, whilst prescribing the admission of foreigners on the same terms as nationals, reserve for the executive authorities the power to take measures restricting the rights granted to foreign workers. Such measures may not be taken unless nationals of the country of residence of the foreigner are less well treated in his country of origin than the nationals of the latter. There is no compulsion on the executive authorities to impose such inequality of treatment as a measure of retaliation, for in every case where the law allows recourse to retaliation the authorities are free to decide whether to make use of this power or not.

Measures reserving the right of retaliation and allowing if need be the exclusion of foreigners from the scope of insurance are to be found in the laws in force in Czechoslovakia (section 249 of the Act), France (section 158 of the Social Insurance Code for Alsace-Lorraine), Germany (section 158 of the Social Insurance Code), Poland (section 1 of the Act of 6 July 1923), and the Serb-Croat-Slovene Kingdom (section 8 of the Act). In all these laws it is left to the discretion of the executive authorities whether the measures of retaliation in question shall be applied or not.

The Polish and Yugoslav Acts lay down in more detail that the right of retaliation may be used only against nationals of those States which, having instituted a system of workers' insurance, do not grant the same treatment to Polish or Yugoslav nationals living on their territory as to their own nationals.

The Czechoslovak Act merely lays down that the insurance of families may be made subject, by way of Decree, to special regulations, which are to take into account the equality or inequality of treatment granted to Czechoslovak nationals in the matter of social insurance.

SPECIAL CONDITIONS FOR FOREIGN WORKERS LIVING TEMPORARILY IN THE COUNTRY

The importance of admitting foreign workers to insurance differs according as they are living only temporarily in the territory of the country where they work or have established themselves there permanently or for a considerable period. A foreign worker who is employed for a specified period (a season or the time needed to finish a certain job) usually leaves his home and family behind in his own country. Sometimes his stay on foreign territory is limited to the time needed for the purpose of his daily work, and he crosses the frontier every day. If in this way he remains in his own country, living in a frontier district, it is usually easy for him to go home if he falls ill. If he belongs to a sickness fund in the country where he works, and that fund has not entered into an agreement with the doctors, chemists, or hospitals of the country where he resides during his illness, he cannot obtain the benefits in kind to which he is entitled, unless he is treated away from home. Consequently, a worker who is temporarily employed abroad and finds it easy to return home if he falls ill finds it to his interest to insure in an institution in his own country, to which he must contribute as a voluntary member if his rights are to be maintained, unless

an agreement to the contrary has been concluded between the States concerned.

From the point of view of the administration of the insurance institutions, the admission of workers employed on a temporary basis in frontier districts is a source of complication owing to the difficulty of keeping a check of a floating population of workers and organising the medical supervision of sick persons living across the frontier. It follows that the inclusion of foreign workers in frontier districts in the scope of compulsory insurance is of interest only if accompanied by measures facilitating the admission of such workers to insurance benefits, even if they do not live on the territory where the fund in which they are insured is situated.

These are the considerations which govern the provisions in force in Czechoslovakia, France (Alsace-Lorraine), Germany, Great Britain, the Irish Free State, and Norway with respect to the position of foreign workers whose employment in the country in question is of limited duration.

The German Social Insurance Code (section 168) leaves it to the Government to decide how far temporary workers are to be exempt from the obligation to insure. According to an Order of 17 November 1923, foreign workers employed for a specified period in frontier districts (seasonal workers, for instance) are not liable to insure. These provisions have been maintained in Alsace-Lorraine. The exclusion of foreign temporary workers, established by the German Code and the law in force in Alsace-Lorraine, is not absolute, and in both cases they may be made liable to insure on condition that a reciprocity treaty has been concluded with their country of origin.

Such treaties have been concluded between Germany and Austria (8 July 1926), and between France and the Commission for the Government of the Saar Basin (27 May 1926). They make insurance compulsory for foreign workers staying even for a limited period on the territory of the contracting States, and in certain cases give such workers the right to choose the insurance system in force in their own country. In order that the system established by these treaties in favour of temporary workers may be fully turned to account, they make provision, in accordance with section 157 of the German Insurance Code, which is also in force in Alsace-Lorraine, for administering the insurance system of one State in the territory of the other.

The laws of Great Britain and Northern Ireland and of the Irish Free State provide for the conclusion of international agreements to secure that any person will still be regarded as insured if he proceeds

to a country in which there is an insurance system comparable with that in force in his own country (section 44 of the British Act and section 32 of the Act of 1911 in force in the Free State). An agreement of this kind has been concluded between Great Britain and the Irish Free State (sections 19 and 20 of the British Act and the Order of 1924 concerning the reciprocity treaty with the Irish Free State, and section 17 of the Irish Act of 1923 and the Irish Order of 29 February 1924). According to this agreement persons leaving Great Britain for a temporary stay in Ireland, or vice versa, continue to be members of the approved society to which they belong when they leave the country; but their contributions are at the rate in force in the country to which they go, and they are entitled to the benefits allowed by the law of that country. In the event of permanent settlement, and employment in the new country the insured person must choose a society situated in the country where he has settled, usually before the end of the second half-year following that during which he ceased to be employed in his country of origin. In this case the actuarial reserves accorded to him are transferred to the society he has chosen. If before the expiry of this period he fails to choose an insurance society in the country where he lives, he is automatically registered as a member of the Deposit Contributors' Fund.

The position of seamen working on board vessels which touch at the ports of several States is in some respects similar to that of workers in frontier districts. Such seamen have the same interest in continuing to belong to a fund in the country where they have their home, on condition, however, that if they fall ill when on foreign territory and cannot be repatriated, they are able to claim benefit.

These are the reasons which gave rise to the treaty of 15 December 1925, concluded by Czechoslovakia and Germany with a view to determining the conditions of employment and social insurance of the crews of vessels navigating the Elbe (*Reichsgesetzblatt*, 1925, Part I, page 1142). According to this treaty the German crews, domiciled in Germany, of vessels of Czechoslovak nationality remain subject to the obligations and entitled to the benefits defined in German insurance legislation. On the other hand, the Czechoslovak insurance laws apply to Czechoslovak crews domiciled in Czechoslovakia who are employed on German vessels. Like the Austro-German and Franco-Saar treaties already mentioned, this treaty also provides for facilities for the administration of the insurance system of one State on the territory of the other.

The Norwegian Act exempts from liability to insurance foreigners entitled, in case of sickness, to benefits provided in virtue of the legislation of their country of origin. These provisions concern foreigners who come to work temporarily in Norway and whose insurance rights in their own country are maintained. Further, the Act of 1 July 1926, which amends subsections 2 and 3 of section 76 of the Act of 6 August 1915, provides that the King may issue regulations necessary for the application of the convention concerning timber floating on the River Pasvik, concluded between Norway and Finland. On condition of reciprocity, the King may conclude agreements with foreign countries for the purpose of allowing exceptions to the existing law in the matter of foreign insured persons entering Norway. Hitherto no use has been made of these fresh powers.

EQUALITY OF TREATMENT ON CONDITION OF RECIPROCITY

Under the Roumanian Act of 1912 the admission of independent or skilled foreign workers to insurance is subject to the right of Roumanians to engage in an occupation in the country of origin of the foreigner. The Act makes insurance compulsory for the members of workers' guilds, which are open to:

- (1) Skilled workers and independent workers combined in brotherhoods.
- (2) General, or unskilled workers.

The latter are admitted to the guilds irrespective of nationality and thus automatically become members of the insurance institutions (sections 2 and 115).

Foreign skilled or independent workers may not carry on in Roumania one of the trades covered by the Act on the organisation of trades and social insurance, unless Roumanians have the same rights in their country of origin. The Central Office may, however, grant a permit to carry on such a trade even in the absence of reciprocity (section 5), but this clause does not apply to persons living in Roumania who are without nationality.

Foreigners entitled to carry on one of the trades covered by the Act, and actually doing so are bound to belong to a brotherhood and are therefore liable to insure, but no foreigner may carry on a trade on his own account or as a skilled worker unless he has been given a permit to do so, and such permits are subject to reciprocity

as regards the right to work. It matters little whether this reciprocity is secured by legislative provisions (legislative reciprocity) or diplomatic agreements (diplomatic reciprocity).

§ 2. — The Right to Benefit

No insurance law fixes special rates of contribution for foreigners and their employers, and if the State shares in defraying the cost of insurance its share is never reduced because the insured person happens to be a foreigner. In view of this equality of contributions, it might be assumed that there should be equality in the right to benefits. In point of fact, however, a foreigner who is allowed to insure may find himself deprived of the right to certain benefits, to which nationals are entitled. If this inequality of treatment related to the more important forms of insurance benefits it would place the foreigner in a particularly unfavourable situation. Although bound to contribute, he would find himself deprived of the fruit of his contributions. Where, in spite of the payment of contributions, valuable rights to benefits are nevertheless refused, the inequality may be considered as more burdensome and serious than simple exclusion from the scope of insurance.

There is no law inflicting so marked an inequality of treatment on foreign workers. It is true that, by the power of retaliation established in Czechoslovakia, France (Alsace-Lorraine), Germany, Poland, and the Serb Croat-Slovene Kingdom, measures may be adopted with regard to foreign workers which maintain their obligations and restrict their rights, no limit being placed to the restrictions within the discretion of the executive authorities; but hitherto use has never been made of this power of retaliation.

Further, the loss of the right to benefit prescribed under certain laws in the event of expulsion from the country (France (Alsace-Lorraine), section 216 of the Social Insurance Code; Germany, section 216 of the Social Insurance Code; Luxemburg, section 21 of the Act) is similar to the loss incurred by nationals in the event of a sentence of imprisonment, and cannot be considered as placing foreigners at a disadvantage.

In fact, apart from the possibilities of retaliation already mentioned, only two laws place foreigners in a special position as regards benefits.

In Hungary equality of treatment is subject to legislative reciprocity, and foreigners whose relatives are domiciled abroad cannot claim dependants' benefits unless the country in which their relatives live grants reciprocal treatment to the families of Hungarian nationals

insured in such countries (section 66). This limitation of the rights of foreigners relates only to funeral benefit and the family allowance, equal to half the sickness benefit, granted if the insured person is treated in a hospital. It is enforced only if the State in which the family is resident applies a similar limitation to the families of Hungarian nationals.

The exception made by the Lithuanian Act (section 16) with respect to the families of insured foreigners is wider. The insurance benefits payable to the members of the family of insured foreigners are granted only if their State of origin secures by treaty the same privileges for the Lithuanian nationals employed on its territory. This restriction applies even if the relatives of the insured person live in Lithuania. It covers all forms of benefit in cash or in kind (family allowances in the event of hospital treatment for the insured, medical attendance and benefit for the members of his family) This restriction can be removed only by way of a diplomatic treaty securing reciprocity.

§ 3. — Participation in Management

The principle of the equality of rights based on the equality of contributions might be adduced to justify the participation of foreigners on the same terms as nationals in the management of the bodies responsible for administering insurance legislation.

Foreigners, both employers and employed, who share in the cost of insurance, have the same interest as nationals in watching over the administration of their contributions, the fair allocation of benefits, the financial stability and prosperity of the institutions, and the reduction of the risks of illness which will result in a reduction of their burdens. No doubt the collaboration in one and the same institution of employers' and workers' delegates of different nationalities freely elected by the groups they represent would contribute to a better understanding of the common interests of nationals and foreigners working in the same country. Yet it is somewhat of an exception that the law allows foreigners to represent a group of insured persons on the institutions responsible for enforcing or supervising the administration of insurance.

The fact is, however, that the function of the managers of funds, and the members of the supervisory or judicial institutions involve rights of regulation, investigation or decision which belong only to the public authorities or their representatives. The right to share in drafting the law and supervising its observance is reserved to

nationals, and in many countries this principle is an obstacle to the admission of foreigners to the institutions engaged in the administration of social insurance.

Nevertheless the British, Lithuanian, Irish, Portuguese, Norwegian, Russian, and Swiss laws contain no provision excluding foreigners from these institutions. In Great Britain and the Irish Free State the power of foreigners to share in the administration of insurance is limited to the management of approved societies, supervisory and judicial functions being performed by departments of the central Government. In Norway their share in administration is confined to local funds, the higher administrative functions and inspection being reserved for nationals. On the contrary, wherever the law allows the participants in insurance (employers and workers) the right to elect representatives to the institutions, foreigners have the same rights as nationals. The restrictions on participation apply to eligibility, and not to the electorate. Thus eligible (section 12). The Esthonian legislation concerning insurance the German Insurance Code lays down that only Germans shall be insurance authorities contains a similar provision, and also the laws of Czechoslovakia (section 33, subsection 1; section 200, subsection 2), France (miners and Alsace-Lorraine, Social Insurance Code, section 12), Hungary (section 110, subsection 1), Poland (section 62, subsection 3), Luxemburg (section 55), Roumania (sections 194 and 227), and the Serb-Croat-Slovene Kingdom (sections 131 and 163). Under section 249 of the Czechoslovak Act, however, foreigners living in Czechoslovakia may be granted eligibility on condition of reciprocity.

APPENDIX

LIST OF PRINCIPAL LEGAL TEXTS AND DOCUMENTS USED IN THE REPORT ON COMPULSORY SICKNESS INSURANCE

ABBREVIATIONS

International Publications: A.B. = *Annuaire de la législation du travail*, published by the Belgian Labour Office, B.B. = *Bulletin of the International Labour Office*, Basle (1902-1919); L.S. = *Legislative Series of the International Labour Office*, Geneva (since 1920).

For other abbreviations, see the footnotes given with the list of texts for each country

AUSTRIA¹

GENERAL LEGISLATION

Act of 30 March 1888 on Workers' Sickness Insurance, new text promulgated by the Order of 20 November 1922. B.G.Bl., 1922, No. 859; L.S., 1922, Aus. 6.

Sickness Insurance Amendment Acts, Nos VII, XVII to XXI

No. VII, 21 October 1921. B.G.Bl., 1921, No. 581.

No. XVII, 3 February 1923. B.G.Bl., 1923, No. 73, L.S., 1923, Aus. 3

No. XVIII, 21 June 1923. B.G.Bl., 1923, No. 342.

No. XIX, 26 September 1923. B.G.Bl., 1923, No. 539.

No. XX, 27 March 1924. B.G.Bl., 1924, No. 90; L.S., 1924, Aus. 2.

No. XXI, 30 June 1924. B.G.Bl., 1924, No. 214; L.S., 1924, Aus. 2.

Act of 18 March 1925, concerning simplification of the management of sickness funds. B.G.Bl., 1925, No. 115.

Act of 28 December 1926, on the organisation of sickness funds. B.G.Bl., 1927, No. 3.

Act of 29 December 1926 concerning the sickness unemployment, accident, and pensions insurance of salaried employees. B.G.Bl., 1926, No. 88; L.S., 1926, Aus. 6

Act of 1 April 1927 on workers' insurance. B.G.Bl., 1927, No. 32, L.S., 1927, Aus. 4,

SPECIAL LEGISLATION

Agricultural Workers

Burgenland

Act of 7 March 1925 on the sickness insurance of workers and salaried employees employed in agriculture and forestry. L.G.Bl., 1925. No. 17

¹ Abbreviations B.G.Bl. = *Bundesgesetzblatt*, L.G.Bl. = *Landesgesetzblatt*.

Carinthia

Act of 26 May 1925 on the sickness insurance of workers employed in agriculture and forestry. L.G.Bl., 1925, No. 27.

Lower Austria

Act of 4 February 1925 on the sickness insurance of persons employed solely or mainly in agriculture L.G.Bl., 1925, No. 9.

Salzburg

Act of 6 December 1902 on communal sickness funds for domestic servants and day-labourers. L.G.Bl., 1902, No. 5.

Styria

Act of 20 March 1925 on the sickness insurance of persons employed in agricultural and forestry undertakings L.G.Bl., 1925, No. 26.

Tyrol

Act of 16 December 1924 on the regulation of sickness insurance for workers and domestic servants in agriculture and forestry. L.G.Bl., 1924, No. 5.

Vienna

Act of 13 February 1925 on the sickness insurance of persons employed solely or mainly in agriculture L.G.Bl., 1925, No. 11.

Voralberg

Act of 3 February 1925 on the sickness insurance of persons employed in agriculture. L.G.Bl., 1925, No. 5.

Officials

Act of 13 July 1920, on the sickness insurance of State officials. B.G.Bl., 1920, No. 311

Act of 10 March 1922 concerning the extension of sickness insurance under the Act of 13 July 1920 (amendment No. I). B.G.Bl., 1922, No. 154.

Act of 19 July 1923 to amend and supplement certain provisions of the Act of 13 July 1920. B.G.Bl., 1923, No. 429.

Act of 2 July 1925 to amend the Act of 13 July 1920. B.G.Bl., 1925, No. 220.

Act of 28 July 1925 to amend and supplement certain provisions of the Acts of 13 July 1920 and 10 March 1922. B.G.Bl., 1925, No. 283.

REPORTS

Statistics of the sickness insurance funds (*Official Bulletin of the Ministry of Social Administration* · non-official part: "Social Insurance"):

Year covered

1918	1921, No. 13.
1919	1922, No. 9.
1920	1924, Nos 1-2.
1921	1924, Nos 7-8.
1922	1925, No. 1.
1923	1925, Nos 9-10.
1924	1926, Nos. 4-5.
1925	1927, Nos. 6-7.

Report of the Association of Sickness Funds in Vienna, Lower Austria, and Burgenland, years 1922, 1923, and 1924.

Annual report of the Vienna General Workers' Sickness and Relief Fund for 1924.

Statistics of the Mining Benefit Funds, 1919 to 1924 (*Official Bulletin of the Ministry of Social Administration*, 1926, Nos. 7-8).

BELGIUM

Seamen

SPECIAL LEGISLATION

Commercial Code (sections 102 et seq.).

Act of 21 July 1844 (section 11): the Relief and Provident Fund for Seamen Sailing under the Belgian Flag.

Decree of 28 February 1885 establishing the rules of the Fund, amended by the Decrees of 5 June 1888, 29 October 1888, 30 September 1900, 31 October 1908, 25 June 1922, 20 February 1923, 17 March 1925, 24 March 1926.

REPORTS

Annual reports of the work of the Relief and Provident Fund for Seamen Sailing under the Belgian Flag:

Year covered

1912	<i>Moniteur belge</i> ,	20 September 1913.
1913	" "	16-17 November 1921.
1920	" "	16 December 1921.

Reports to the Minister of Railways, Shipping, Posts, and Telegraphs:

Year covered

1921	19 June 1922
1922	19 April 1923.
1923	21 February 1924.
1924	29 April 1925.

BULGARIA ¹

GENERAL LEGISLATION

Act of 6 March 1924 on social insurance (Ukase No 1). D.V., 25 March 1924, p. 289; L.S., 1924, Bulg. 1.

Ukase No 26 of 25 June 1924, issuing Regulations for the administration of the Act of 6 March 1924 on social insurance. D.V., 28 June 1924, p. 69.

REPORTS

Figures showing the results of the administration of the Act of 6 March 1924 were published in the *Statistical Year Book for the Kingdom of Bulgaria* (1923-1924) and the *Monthly Statistical Bulletin* (March 1926, No. 3).

CHILE ²

GENERAL LEGISLATION

Act No. 4054 of 8 September 1924 on compulsory insurance against sickness, invalidity, and industrial accidents. D.O., No. 13987, 26 September 1924, p. 2291

Decree No 34 of 22 January 1926, issuing the definitive text of Act No 4054 of 8 September 1924 on sickness and invalidity insurance. L.S., 1926, Chile 1.

¹ Abbreviation D.V. = *Dzvoen Vestnik* (Official Gazette)

² Abbreviation D.O. = *Diario oficial* (Official Gazette)

CZECHOSLOVAKIA¹

GENERAL LEGISLATION

Act of 9 October 1924 on the insurance of workers against sickness, invalidity and old age. S.Z.N., C 112, No 221. L.S., 1924, Cz 4.

SPECIAL LEGISLATION

Miners

Act of 11 July 1922 concerning insurance by the miners' benefit societies. S.Z.N., No. 23

Officials

Act of 15 October 1925 on the sickness insurance of public officials and employees S.Z.N., No 221

REPORTS

Sickness Insurance Statistics, compiled by the Ministry of Social Welfare:

Year covered	
1920	Prague, 1923
1921	„ 1923
1922	„ 1924
1923	„ 1926

Statistics of the miners' benefit societies, 1919-1923 (*Report of the Statistical Office of the Czechoslovak Republic*, 1926, Nos. 44 to 45, pp. 291 to 308).

ESTHONIA

GENERAL LEGISLATION

(Russian) Act of 23 June (6 July) 1912 on workers' sickness insurance. Industrial Labour Code, 1913 edition, B.B., 1913, p. 129.

Amended by the Acts of 18 June 1917 and 3 February 1920.

FRANCE

Alsace-Lorraine²

GENERAL LEGISLATION

Acts

Social Insurance Code of 19 July 1911 (revised and annotated translation, first edition, Strasburg, 1921)

Act of 17 October 1919 concerning the transitional system for Alsace and Lorraine. B.O.G., 1919, p. 233.

Act of 18 April 1922 to ratify the Decree of 10 February 1921. B.O.G., 1922, p. 103.

Act of 17 July 1922 to ratify the Decree of 28 October 1920. B.O.G., 1922, p. 167.

¹ Abbreviations S.Z.N. = *Sbírka Zákonů a Nařízení* (Collection of Acts and Decrees)
² Abbreviation B.O.G. = *Bulletin de l'Office général des Assurances Sociales* (Bulletin of the General Social Insurance Office)

Act of 30 December 1923 to extend to the staff of the Alsace and Lorraine Railways the pensions system in force for the other French main lines B.O.G., 1924, p. 3.

Act of 19 February 1924 to ratify the Decree of 15 March 1920 B.O.G., 1924, p. 44

Act of 1 June 1924 to put into operation French civil legislation in the Departments of Bas-Rhin, Haut-Rhin, and Moselle. B.O.G., 1924, p. 139.

Act of 24 July 1925 to reorganise the administrative system in the Departments of Bas-Rhin, Haut-Rhin, and Moselle B.O.G., 1925, p. 137

Act of 6 June 1926 to ratify the Decree of 28 December 1924 B.O.G., 1926, p. 87.

Decrees

Decree of 15 March 1920 to define the conditions of applying social insurance legislation to the safety representatives of miners in Alsace and Lorraine. B.O.G., 1920, p. 123.

Decree of 28 October 1920 to adapt the provisions of the Social Insurance Code of 19 July 1911 and subsequent Acts in force in the Departments of Bas-Rhin, Haut-Rhin, and Moselle, concerning sickness insurance and invalidity insurance. B.O.G., 1920, p. 267.

Decree of 19 February 1921 to amend sections 503 et seq. of the Social Insurance Code of 19 July 1911 concerning approved voluntary funds. B.O.G., 1921, p. 63

Decree of 14 October 1921 and 27 January 1922.

- (1) to introduce maternity legislation in the Departments of Bas-Rhin, Haut-Rhin, and Moselle as from 1 January 1922;
- (2) to postpone until 1 May 1922 the putting into operation of the said legislation. B.O.G., 1922, pp. 4 and 47.

Decree of 1 March 1922 to give effect to the recommendations approved by the Council of the League of Nations concerning social insurance in Alsace and Lorraine. B.O.G., 1922, p. 76.

Decree of 11 July 1923 issuing Public Administrative Regulations under the Act of 17 April 1923 B.O.G., 1923, p. 149.

Decree of 14 May 1924 concerning exemption from sickness insurance of officials subject to the Act of 9 June 1853 on civil pensions, and officials recruited since the armistice covered by section 1 of the Act of 22 July 1923 on the status of officials in Alsace and Lorraine. B.O.G., 1924, p. 101.

Decree of 28 December 1924 concerning the exemption from sickness insurance of workers holding commissions under the postal and telegraph service in the Departments of Bas-Rhin, Haut-Rhin, and Moselle. B.O.G., 1925, p. 4.

Decree of 21 December 1925 amending certain provisions of the Social Insurance Code of 19 July 1911 concerning sickness insurance. B.O.G., 1924, p. 31.

REPORTS AND OTHER DOCUMENTS

Bulletin of the General Social Insurance Office of Alsace and Lorraine. Strasbourg, 1919-1926.

Annual Statistical Reports of the Statistical Office of Alsace and Lorraine Strasbourg, 1921-1924.

PASTEUR CENTENARY INTERNATIONAL EXHIBITION. *Social Insurance in Alsace and Lorraine* Strasbourg, 1923.

G. MOULIN *Les Réformes du régime des assurances sociales en Allemagne depuis la Révolution de 1918* (Reforms of the Social Insurance System in Germany since the 1918 Revolution) Les Presses Universitaires, Paris, 1925

Seamen¹

SPECIAL LEGISLATION

Acts

Act of 29 December 1905 concerning registered seamen and the amendment of certain sections of the Act of 21 April 1898. J.O., 30 December 1905; B.L., 1906, No. 2707, p. 1457; B.B., 1907, p. 24.

Act of 19 April 1906 on the mercantile marine J.O., 20 April 1906; B.L., 1906, No. 2722, p. 134.

Act of 14 July 1908 concerning pensions paid by the Seamen's Disablement Fund. J.O., 15-16 July 1908, p. 4910, B.L., 1908, No. 2972, p. 1257.

Act of 19 April 1910 to amend section 12 of the Act of 29 December 1905 on the French Seamen's Provident Fund. J.O., 22 April 1910, p. 3694.

Act of 13 July 1911 to add a subsection to section 9 of the Act of 29 December 1905 on the Seamen's Provident Fund. J.O., 19 July 1911, p. 5977; B.B., 1912, p. 377.

Act of 18 January 1918 to amend subsection 5 of section 5 of the Act of 29 December 1905 setting up the French Seamen's Provident Fund. J.O., 22 January 1918, p. 810; B.L., 1918, No. 218, p. 116.

Act of 30 December 1920 to raise the rate of pensions paid by the Seamen's Disablement Fund and the Seamen's Provident Fund for the benefit of French seamen. J.O., 31 December 1920, p. 21778; B.L., 1920, No. 288, p. 5742.

Act of 14 August 1924 to increase the rate of pensions paid by the Seamen's Disablement Fund. J.O., 15 August 1924, p. 7660.

Decrees

Decree of 14 April 1906 issuing Public Administrative Regulations under the Act of 29 December 1905 on the French Seamen's Provident Fund. J.O., 22 April 1906; B.L., 1906, No. 2731, p. 597.

Decree of 16 August 1908 concerning the administration of the Act of 14 July 1908 on pensions of registered seamen. J.O., 20 August 1908.

Decree of 21 April 1909 to amend the Decree of 16 August 1908 with respect to the dates of examination of members of the Seamen's Provident Fund B.O.M., 1909, Principal Bulletin 13, p. 385.

Decree of 16 November 1911 for the application of the provisions of the Acts of 29 December 1905 and 14 July 1908 to French seamen sailing with the permission of the Minister of Marine on vessels of the Shereefian Government J.O., 19 November 1911, p. 9216.

Decree of 8 September 1912 issuing Public Administration Regulations under sections 262 and 263 of the Commercial Code, concerning the schedule of expenditure on the treatment and repatriation of seamen in the mercantile marine left abroad on account of sickness or injury J.O., 15 September 1912, p. 8084.

Decree of 30 December 1920 to prolong for a period of three years the provisions of the Decree of 15 February 1919 empowering the colonial and consular maritime authorities temporarily to increase the rates fixed by the Decree of 8 September 1912 for the treatment and repatriation of seamen in the mercantile marine left abroad owing to sickness or injury J.O., 4 January 1921, p. 240.

Decree of 12 July 1924 to define the composition of the special examination committees Second supplement to the *Collection of Acts and Regulations concerning the French Mercantile Marine*, p. 143.

Ministerial Instructions

Ministerial Instruction of 20 April 1906 on the French Seamen's Provident Fund. B.O.M., 1906, Principal Bulletin 12, p. 370.

¹ Abbreviations J.O. = *Journal Officiel* (Official Gazette), B.L. = *Bulletin des Lois* (Bulletin of Acts), B.O.M. = *Bulletin officiel de la Marine* (Official Shipping Bulletin).

Ministerial Instruction of 20 October 1907 on the French Seamen's Provident Fund B.O.M., 1907, Principal Bulletin 33, p. 1197.

Ministerial Instruction of 31 December 1920 concerning the administration of the Act of 13 December 1920 on the Seamen's Disablement Fund and the French Seamen's Provident Fund J.O., 5 January 1921, p. 290.

REPORTS AND OTHER DOCUMENTS

Georges RIPERT. *Droit Maritime* (Maritime Law) Second edition. Paris, Rousseau et Cie, 1922. Vol I, Chapter III, pp 574-592; 613-629; 671-699.

R RISSEN *Note actuarielle sur la Caisse de prévoyance des marins français* (Actuarial Note on the French Seamen's Provident Fund) *Quarterly Bulletin of the French Institute of Actuaries*, March 1914

M. CAMBON *La Caisse Nationale de la prévoyance des marins français* (The French Seamen's Provident Fund). Paris, Figuière, 1926

Miners¹

Acts

Act of 29 June 1894 on miners' benefit and pension funds. J.O., 30 June 1894, B.L., 1894, No. 1637, p. 1049.

Act of 16 July 1896 to amend section 11 of the Act of 29 June 1894 on miners' benefit and pension funds. J.O., 18 July 1896, B.L., 1896, No. 1793, p. 233.

Act of 1 April 1898 concerning mutual benefit societies J.O., 5 April 1898; B.L., 1898, No. 1954, p. 1056.

Act of 9 April 1898 concerning workmen's compensation for industrial accidents J.O., 10 April 1898; B.L., 1898, No. 1977, p. 837.

Act of 2 April 1906 concerning the participation of miners' safety representatives in the miners' benefit and pension funds J.O., 7 April 1906; B.L., 1906, No. 2774, p. 2469.

Act of 25 February 1914 to amend the Act of 29 June 1894 and set up an independent pension fund for miners. J.O., 26 February 1914; B.L., 1914, No. 124, p. 427.

Act of 23 November 1918 to amend the penultimate subsection of section 4 of the Act of 25 February 1914, amending the Act of 29 June 1894, and setting up an independent pension fund for miners, and the last subsection of section 1 of the Act of 29 June 1894 on miners' benefit and pension funds. J.O., 25 November 1918, B.L., 1918, No. 238, p. 2659.

Act of 14 March 1923 to amend section 16 of the Act of 29 June 1894 on miners' benefit societies. J.O., 16 March 1923, p. 2498.

Act of 24 December 1923 to improve miners' old-age and invalidity pensions. J.O., 25 December 1923, p. 11989, and 30 December 1923, p. 12204; L.S., 1923, Fr. 3 A.

Act of 28 December 1923 to extend the provisions of the special legislation on miners' pensions and benefit to persons employed in industries subsidiary to mining undertakings J.O., 29 December 1923, p. 12156, L.S., 1923, Fr. 3 B.

Decrees

Decree of 25 July 1894 issuing Public Administrative Regulations under the Act of 29 June 1894 on miners' benefit and pension funds J.O. 26 July 1894, B.L., 1894, No. 1649, p. 340

Decree of 14 August 1894 issuing Public Administrative Regulations under sections 1, 2, 3, and 28 of the Act of 29 June 1894 on miners' benefit and pension funds. J.O., 15 August 1894, B.L., 1894, No. 1649, p. 347

¹ Abbreviations: J.O. = *Journal Officiel* (Official Gazette), B.L. = *Bulletin des Lois* (Bulletin of Acts), B.O.T. = *Bulletin de l'Office du Travail* (Bulletin of the Labour Office)

Decree of 28 December 1906 issuing Public Administrative Regulations under the Act of 2 April 1906 on the participation of miners' safety representatives in the miners' benefit and pension funds J. O., 3 January 1907, B.O.T., 1907, p. 261

Decree of 13 July 1914 issuing general regulations under the Act of 25 February 1914 amending the Act of 29 June 1894 and setting up an independent pension fund for miners J.O., 14 July 1914, B.L., 1914, No. 133, p. 1868.

Decree of 11 February 1920 placing slate quarries in the same position as mining undertakings with respect to the administration of subsection 2 of section 1 and section 3 of the Act of 29 June 1894 J. O., 13 February 1920, p. 2354

GERMANY¹

GENERAL LEGISLATION

Notification of the new text of the Federal Insurance Code of 15 December 1924. R.G.B., 1924, Part I, p. 779, L.S., 1924, Ger. 10

Notification of the Federal Chancellor of 17 November 1913 concerning the exemption of casual work from compulsory insurance R.G.B., p. 726

Order of 10 January 1925 of the Minister of Labour concerning limits of annual income and annual earnings in sickness insurance. R.G.B., 1925, I, p. 2.

Act of 9 July 1926 to amend Book II of the Federal Insurance Code (Maternity Insurance Act). R.A.B., p. 246

Regulations of 25 May 1925 of the Federal Committee of Medical Practitioners and Sickness Funds R.A.B., 1925, p. 264

Order of 17 February 1925 on the procedure and expenditure of the Federal Arbitration Committee. A.N., 1925, p. 192

Instructions issued by the Federal Committee of Medical Practitioners and Sickness Funds:

12 May 1924 concerning the general contents of contracts with medical practitioners. R.A.B., 1924, p. 205

14 November 1925 concerning the medical service. R.A.B., 1925, p. 541.

14 November 1925 concerning the admission of medical practitioners to treat insured persons R.A.B., 1925, pp. 539 and 540.

15 May 1925 concerning economy in the prescription of drugs. R.A.B., 1925, p. 255

7 January 1927 concerning the treatment of insured persons by specialists R.A.B., 1927, pp. 48 and 49

Notification of 22 December 1926 of the Prussian Minister for Social Administration on schedules of medical fees *Volkswohlfahrt*, p. 288

SPECIAL LEGISLATION

Miners

Notification of 1 July 1926 of the new text of the Miners' Insurance Act. R.G.B., 1926, Part I, p. 364; L.S., 1926, Ger. 5

REPORTS

General System

Sickness insurance statistics for the year

1913:	<i>Statistik des Deutschen Reichs</i> , Vol. 277				
1914:	"	"	"	"	289
1915:	"	"	"	"	294

¹ Abbreviations. R.G.B. = *Reichsgesetzblatt*; R.A.B. = *Reichsarbeitsblatt*, A.N. = *amtliche Nachrichten des Reichsversicherungsamts* (Official Reports of the Federal Insurance Office)

1916-1919	<i>Statistik des Deutschen Reichs</i> , Vol	298
1920-1921	" " " "	303
1922-1923	" " " "	324
1924	" " " "	331
1925	" " " "	338

Quarterly Review of the *Statistik des Deutschen Reichs*, 1914, 1915, 1920-1925 (Federal Statistical Office)

Official information from the Reichsversicherungsamt, 1914-1926.

Wirtschaft und Statistik, fortnightly publication of the Federal Statistical Office, edited by Reimar Hobbing, Berlin, S.W 61, Grossbeerenstrasse, 171 1924-1926.

Year Book of the Reichsversicherung, 1925-1926 by J. Eckert, O. K. Hartmann, and Dr O. Paul, published by Reimar Hobbing, Berlin, S.W 61., Grossbeerenstrasse, 17.

Year Book of the Hauptverband deutscher Krankenkassen, 1925-1926 published by the Verlagsgesellschaft deutscher Krankenkassen m.b.h., Berlin.

Annual Report of the Gesamtverband der Krankenkassen Deutschlands, 1924-1925, and 1926, published by the Gesamtverband der Krankenkassen Deutschlands e.V., Berlin.

Special System (Miners)

First Annual Report of the Reichsknappschaftsvereins, presented to the General Meeting, 23 November 1926.

GREAT BRITAIN

GENERAL LEGISLATION ¹

Acts

Act of 7 August 1924 to consolidate the enactments relating to national health insurance. L.S., 1924, G.B. 6.

Act of 10 November 1921 to extend temporarily the period during which persons who are unemployed may remain insured under the general provisions of the National Health Insurance Acts, 1911-1921. L.S., 1921, Part II, G.B. 1.

Act of 29 May 1924 to make further provision with respect to the cost of medical benefit, and to the expenses of the administration of benefits under the Acts relating to national health insurance, and to amend section 29 of the National Health Insurance Act, 1918, and for purposes connected therewith. L.S., 1924, G.B. 2

Act of 7 August 1925 to make provision for pensions for widows, orphans and persons between the ages of 65 and 70, and for the payment of contributions in respect thereof, and to amend the enactments relating to health and unemployment insurance and old-age pensions (sections 37 and 38 and Fourth Schedule). L.S., 1925, G.B. 7

Act of 16 June 1926 to make provision for reducing, in respect of certain services, the charges on public funds and for increasing, by means of the payment into the Exchequer of certain sums and otherwise, the funds available for meeting such charges, and to amend accordingly the law relating to national health insurance . . . and for purposes related or incidental to the matters aforesaid. L.S., 1926, G.B. 7.

¹ Abbreviation N.H.I. = *Statutes, Regulations and Orders relating to National Health Insurance* London, H.M. Stationery Office, n.d. 709 pp. Price 5s.

Orders

Consolidated Order of 1924 on national health insurance (subsidiary employments). N.H.I., p. 632.

Order of 1924 on national health insurance (out-workers). N.H.I., p. 638.

Order of 1924 on national health insurance (employment under local and public authorities). N.H.I., p. 640.

Order of 1924 on national health insurance (share fishermen). N.H.I., p. 652.

Order of 1924 on national health insurance (Irish Free State Reciprocal Arrangements). N.H.I., p. 649

REPORTS

Report for 1912-1913 on the Administration in England of the National Insurance Act, Part I (Health Insurance). Cmd. 6907,

Report on the Administration of National Health Insurance during the years 1914 to 1917. Cmd 8890.

First, second, third, fourth, fifth, sixth, and seventh annual reports of the Ministry of Health Cmd 913, 1446, 1713, 1944, 2213, 2450, and 2724.

Report on the Administration of National Health Insurance in Scotland during the years 1917 to 1919. Cmd 827.

First, second, third, fourth, fifth, sixth, and seventh annual reports of the Scottish Board of Health Cmd. 825, 1319, 1697, 1887, 2156, 2416, and 2674.

National Health Insurance Fund Accounts for the years ended 31 December 1919, 1921, 1922, and 1923.

Report by the Government Actuary on the Valuations of the Assets and Liabilities of Approved Societies as on 31 December 1918. Cmd 1668.

Report by the Government Actuary on the Second Valuation of the Assets and Liabilities of Approved Societies. 1927. Cmd. 2785.

Interim and further reports of the Departmental Committee on Approved Society Finance and Administration, 1916. Cmd. 8251 and 8396

Report of the Royal Commission on National Health Insurance, 1926. Cmd. 2596.

Appendix to minutes of evidence taken before the Royal Commission on National Health Insurance, Part I, Statements prepared by certain Government Departments 1924

Northern Ireland

GENERAL LEGISLATION

Act of 7 August 1924 to consolidate the enactments relating to national health insurance L.S., 1924, G.B. 6.

Act of 10 November 1921 to extend temporarily the period during which persons who are unemployed may remain insured under the general provisions of the National Health Insurance Acts, 1911-1921 L.S., 1921, Part II, G.B. 1

Act of 5 July 1922 to make further provision with respect to the administration of benefits under the Acts relating to national health insurance in Northern Ireland, to amend section 29 of the National Health Insurance Act, 1918, in its application to Northern Ireland, and for purposes connected therewith. L.S. 1926, G.B. 8.

Act of 29 May 1924 to make further provision with regard to the expenses of the administration of certain benefits under the Acts relating to national health insurance in Northern Ireland, and to amend section 29 of the National Health Insurance Act, 1918, and for purposes connected therewith. L.S., 1924, G.B. 7.

Act of 6 November 1925 to make provision for pensions for widows, orphans and persons between the ages of 65 and 70, and for the payment of contribu-

tions in respect thereof, and to amend the enactments relating to health and unemployment insurance and old-age pensions

Act of 1 June 1926 to make provision for reducing, in respect of certain services, the charges on public funds, and for increasing, by means of the payment into the Exchequer of Northern Ireland of certain sums, and otherwise, the funds available for meeting such charges, and to amend accordingly the law relating to national health insurance . . . and for purposes related or incidental to the matters aforesaid L.S., 1926, G.B. 8.

GREECE¹

GENERAL LEGISLATION

Act No. 2868 of 16 July 1922 respecting the compulsory insurance of wage-earning and salaried employees in private undertakings. E.K., 1922, No. 119, p. 554; L.S., 1922, Gr. 3

Legislative Decree of 19 November 1923 to amend and supplement Act No. 2868 respecting the compulsory insurance of wage-earning and salaried employees. E.K., No. 345, 28 November 1923, p. 2493; L.S., 1923, Gr. 6 A.

Royal Decree of 8 December 1923 to consolidate the provisions of Act No. 2868, and of the Legislative Decree of 19 November 1923, to amend and supplement the said Act. E.K., 1923, No. 373, 24 December 1923, p. 2690; L.S., 1923, Gr. 6 B.

Decree of 4 February 1925 to appoint the members of the Supervisory Workers' Insurance Council. E.K., 1925, No. 32, p. 154, amended by the Decree of 5 March 1925; E.K., 1925, No. 61, p. 335.

UNOFFICIAL DOCUMENTS

Social Insurance Bulletin. Published by the Tobacco Workers' Insurance and Protection Fund, Salonica Nos. 1-2-3, 1927.

HUNGARY²

GENERAL LEGISLATION

Act No. XIX of 6 April 1907 on the sickness and accident insurance of persons employed in industrial and commercial occupations. O.T., 9 April 1907; B.B., 1907, Vol. II, p. 269

Act No. XXXI of 1921 on the organisation of insurance courts

Orders to amend and supplement Act No. XIX of 1907

No. 4700 of 1 January 1918, M.R.T., 1917, pp. 2369-2392.

No. 5400 of 30 September 1919; M.R.T., 1919, p. 730

No. 9522 of 1 November 1920; M.R.T., 1920, p. 579

No. 8524 of 14 October 1921 M.R.T., 1921, p. 260.

No. 3596 of 3 December 1926; B.K., 1926, No. 279.

No. 11200 of 3 December 1923, B.K., 1926, No. 289.

SPECIAL LEGISLATION

Officials

Act No. XLVI of 1921 to establish the medical benefit fund for State officials

Administrative Order No. 40000 of 1923.

REPORTS

Annual reports of the Workers' National Insurance Fund

Year covered	Date of report
1913-1914	1916
1915	1918

¹ Abbreviation E.K. = *Ephemeris Kyberneszos* (Official Gazette).

² Abbreviations O.T. = *Országos Törvénygyűjtemény* (Collection of State Acts). M.R.T. = *Magyarországi Rendeletek Tára* (Collection of State Orders) B.K. = *Budapesti Közlöny* (Budapest Official Gazette)

Year covered	Date of report
1918-1919	1922
1921-1922	1922
1922	1923
1923	1924
1924	1925

IRISH FREE STATE

GENERAL LEGISLATION

Act of 16 December 1911 to provide for insurance against loss of health and for the prevention and cure of sickness and for insurance against unemployment and for purposes incidental thereto B.B., 1912, p. 339, French translation. A.B., 1911, p. 331

Act of 15 August 1913 to amend Parts I and III of the National Insurance Act, 1911. French translation A.B., 1913, p. 364.

Act of 16 March 1915 to amend Part I of the National Insurance Act, 1911.

Act of 17 May 1917 to amend the enactments relating to national health insurance with respect to persons suffering from disablement in consequence of the present war.

Act of 6 February 1918 to amend the Acts relating to national health insurance. French translation: A.B., 1914-1919, Vol. II, p. 454

Act of 15 August 1919 to alter the rate of remuneration for the purposes of exception from insurance under the National Insurance (Health) Acts, 1911 to 1918, and for purposes connected therewith. French translation: A.B., 1914-1919, Vol. II, p. 512.

Act of 20 May 1920 to amend the acts relating to national health insurance. L.S., 1920, G.B. 2.

Act of 28 August 1921 to amend the financial provisions of the National Health Insurance Acts, 1911 to 1920, and to provide for increasing the amounts payable to insurance committees on account of administration expenses and for reducing the number of members of insurance committees.

Act of 10 November 1921 to extend temporarily the period during which persons who are unemployed may remain insured under the general provisions of the National Insurance Acts, 1911 to 1921 L.S., 1921, Part II, G.B. 1.

Act No. 20 of 26 June 1923 to amend and adapt the National Health Insurance Acts, 1911 to 1921. L.S., 1923, I.F.S. 1

Act No. 30 of 28 July 1924 to establish a Medical Certification Fund under the control and management of the Irish Insurance Commissioners, and for that purpose and for other purposes to amend and extend the National Health Insurance Acts, 1911 to 1923. L.S., 1924, I.F.S. 2.

Act No. 36 of 15 July 1925 to make provision for the continuance of the Medical Certification Fund and for that purpose to authorise the payment of certain sums respectively into and out of that fund.

REPORTS

Interim report of the Committee of Enquiry into health insurance and medical services, and appendices Dublin, Stationery Office, 1925

Report on the administration of the National Health Insurance Act, 1911, during the period 1913-1914. Cmd. 7496

Report on the administration of national health insurance during the years 1914 to 1917. Cmd. 8890.

Report on the administration of national health insurance during the period November 1917 to 31 March 1920. Cmd. 1147.

Report on the administration of National Health Insurance in Ireland during the period 1 April 1920 to 31 March 1921.

ITALY (New Provinces) ¹

GENERAL LEGISLATION

Acts

Legislative Decree No. 2146 of 29 November 1925 to extend social insurance legislation to the new provinces. G.U., 12 December 1925, No. 288, p. 4886.

Legislative Decree No. 1308 of 1 July 1926 to amend the Legislative Decree No. 2146 of 29 November 1925 concerning the extension of social insurance legislation to the new provinces. G.U., 1926, No. 179, p. 3476.

Legislative Decree No. 1564 of 13 August 1926 to co-ordinate the sickness insurance provisions in force in the new provinces with those concerning the fair treatment of persons employed in public transport undertakings held by concession. G.U., 1926, No. 216, p. 4120.

Decrees

Royal Decree No. 528 of 4 March 1926 to approve the Regulations for the administration of the Legislative Decree No. 2146 of 29 November 1925 concerning the extension of social insurance legislation to the new provinces so far as sickness insurance is concerned. G.U., 7 April 1926, No. 81, p. 1467.

Ministerial Decrees of 30 April and 31 July 1926 to authorise sickness insurance operations in the territory of the new provinces. G.U., 10 August 1926, No. 184, p. 3549.

JAPAN ²

GENERAL LEGISLATION

Acts

Act No. 70 of 22 April 1922 relating to health insurance. K., No. 2914; L.S., 1922, Jap. 3.

Act No. 34 of 27 March 1926 to amend the Health Insurance Act

Act No. 26 of 27 March 1926 to establish a special account for health insurance.

Factory Act No. 46 of 28 March 1911 as amended by Act No. 33 of 29 March 1923. K., No. 3197, 30 March 1923, L.S., 1923, Jap. 1.

Act No. 22 of 22 July 1924 to amend the Mining Act. K., Special No., 22 July 1924; L.S., 1924, Jap. 2.

Orders

Imperial Ordinance No. 243 of 30 June 1926 respecting the enforcement of the Health Insurance Act.

Order of 2 August 1916 in pursuance of the Factory Act. B.B., 1917, p. 27.

Imperial Ordinance No. 152 of 5 June 1926 respecting the date of bringing into operation of the Industrial Workers' Minimum Wage Act and the Factory Act Amendment Act. K., No. 4135, 7 June 1926; L.S., 1926, Jap. 1 A.

Imperial Ordinance No. 153 of 5 June 1926 to amend the Ordinance for the administration of the Factory Act. K., No. 4135, 7 June 1926. L.S., 1926, Jap. 1 B.

Regulations

Ordinance No. 36 of 1 July 1926 of the Department of the Interior: Regulations for the enforcement of the Health Insurance Act.

¹ Abbreviation: G.U. = *Gazzetta Ufficiale* (Official Gazette).

² Abbreviation: K. = *Kampo* (Official Gazette).

Ordinance No 19 of 3 August 1916 of the Ministry for Agriculture and Trade: Regulations in pursuance of the Factory Act.

Ordinance No. 21 of 3 August 1916 of the Ministry for Agriculture and Trade: Regulations for the employment and relief of miners.

Ordinance No 13 of 7 June 1926 of the Department of the Interior to amend the Regulations for the administration of the Factory Act. K, No. 4135, 7 June 1926, L.S., 1926, Jap. 1 C.

Ordinance No 17 of 24 June 1926 of the Department of the Interior to amend the Regulations for the employment and relief of miners K, No. 4150, 24 June 1926: L.S., 1926, Jap 2 B

LATVIA¹

GENERAL LEGISLATION

Sickness Insurance Code for workers and employees issued by the Codification Section of the Ministry of Justice. 1922 L.S., 1922, Lat. 2.

Order of 14 June 1923 concerning the sickness and accident insurance of workers employed in fisheries V.V., 1923, No 127

Order of 8 September 1923 concerning the insurance of temporary or casual workers. V.V., 1923, No 199

Order of 27 October 1923. concerning the sickness insurance of workers employed in forestry undertakings V.V., 1923, No 241

Regulations of 2 June 1923 concerning the sickness insurance of independent artisans V.V., 1923, No 118

Order of 21 April 1923 concerning the affiliation to sickness funds of workers in newly-established undertakings. V.V., 1923, No 120

Order of 15 January 1924 on the affiliation of undertakings to sickness funds. V.V., 1924, No 15

Order of 22 November 1923 concerning the position of persons called up for military service. V.V., 1923, No 261.

Order of 4 February 1924 concerning the membership in sickness funds of women who are confined before they have acquired a claim to maternity benefit V.V., 1924, No. 30

Order of 7 February 1924 concerning members of a sickness fund who have not received cash benefit in the event of an industrial accident. V.V., 1924, No. 33

Interim Regulations of 11 August 1921 concerning medical benefit granted to members of sickness funds V.V., 1921, No 179.

Regulations of 28 February 1923 concerning the transference of the organisation of medical benefit to the sickness funds. V.V., 1923 No. 48.

Order of 17 August 1923 on the medical assistance granted to members of sickness funds. V.V., 1923, No. 179.

Order of 13 September 1923 concerning the medical assistance for workers. V.V., 1923, No 203.

Resolution of 2 June 1923 concerning cash benefit to be granted to women members of sickness funds after confinement. V.V. 1923, No. 118.

Resolution of 2 June 1923 concerning the qualifying period which women members of a sickness fund must undergo before acquiring the right to cash benefit after confinement. V.V., 1923, No 118.

Order of 25 June 1924 concerning the commencement and period of payment of cash benefit in the event of sickness, accident or confinement. V.V., 1924. No 23.

Order of 17 August 1923 concerning benefits granted to members of the family of insured persons. V.V., 1923, No. 179.

¹ Abbreviation V.V. = *Valdības Vestnesis* (Official Gazette)

Order of 14 June 1923 concerning contributions and cash benefits in the event of an annual holiday or dismissal without notice. V.V., 1923, No. 127. Amended on 15 January 1926 V.V., 1926, No. 14.

Order of 17 August 1923 concerning holidays during sickness. V.V., 1923, No. 179.

Order of 23 April 1923, applying to sickness funds and labour inspectors, concerning returns of wages and the recovery of unpaid contributions V.V., 1923, No. 87.

Regulations of 25 May 1923 on the financial participation of the State in sickness insurance. V.V., 1923, No. 110.

Order of 23 August 1923 concerning the certification by labour inspectors of applications for reimbursement addressed to the State. V.V., 1923, No. 185.

Order of 9 August 1923, on the accounts and information on the changes in the number of insured persons and the members of their families, to be supplied to the Ministry of Labour V.V., 1923, No. 173 Amended on 8 January 1924 V.V., 1924, No. 7.

Regulations of 24 October 1921 on the dates and methods of settling accounts between insurance funds and the mutual accident insurance society. V.V., 1921, No. 243.

Regulations of 2 June 1923 concerning the information to be supplied by employers to insurance funds. V.V., 1923, No. 118.

Order of 14 August 1923 concerning the forms to be used for information supplied by employers to sickness funds. V.V., 1923, No. 177

Regulation of 1 June 1922 on labour protection and workers' insurance. V.V., 1922, No. 126.

Order of 25 January 1924 on the duties of labour inspectors with respect to insurance funds. V.V., 1924, No. 25.

Order of the Ministry of Labour of 12 June 1921 concerning lists of workers and wage books. V.V., 1921, No. 11.

Regulations of 11 May 1921 on free medical treatment in hospitals. V.V., 1921, No. 105.

Regulations of 14 January 1924 on dispensing chemists. V.V., 1924, No. 15.

Amendment dated 25 April 1924 of the Order concerning the sickness insurance of temporary or casual workers. V.V., 1924, No. 95

Amendment dated 29 September 1924 of the Order on the sickness insurance of temporary or casual workers. V.V., 1924, No. 224.

Amendment dated 2 October 1924 of the Regulations on labour protection and workers' insurance. V.V., 1924, No. 235.

Regulations of 8 November 1924 on the cash benefit payable to the members of sickness funds and their families for the feeding of children. V.V., 1924, No. 257

Amendment dated 5 January 1925 of the Regulations concerning the sickness insurance of temporary or casual workers. V.V., 1925, No. 5.

Order of 15 January 1925, concerning amendments of the Regulations on the sickness insurance of independent artisans. V.V., 1925, No. 12.

Rules of the Latvian Federation of Sickness Funds dated 20 May 1925. V.V., 1925, No. 114.

Order of 25 June 1925 appointing a special labour inspector for the inspection of sickness funds V.V., 1925, No. 138

Regulations of 23 October 1925 on the transference of insured persons from one fund to another. V.V., 1924, No. 240.

Rules of the Joint Office of the Riga Sickness Funds, dated 26 October 1925. V.V., 1925, No. 254

Order of 30 December 1925 concerning the average daily earnings of unskilled workers which exempt insured persons from the payment of contributions. V.V., 1926, No. 3.

Amendments dated 18 February 1926 of the Order on the affiliation of undertakings to sickness funds. V.V., 1926, No. 40.

Order of 27 February 1926 on the calculation of the value of board and lodgings for determining sickness fund contributions. V.V., 1926, No. 48.

Order of 27 February 1926 concerning the calculation of the occupational income of share farmers for determining insurance contributions. V.V., 1926, No. 48.

LITHUANIA¹

GENERAL LEGISLATION

Act of 9 December 1925 on sickness funds. V.Z., No. 227, 27 May 1926, L.S., 1925, Lith. 3.

Act of 23 March 1926 on the Superior Social Insurance Office. V.Z., No. 225, 18 May 1926, L.S., 1926, Lith. 1.

Amendment dated 28 September 1926 of the Sickness Funds Act. V.Z., No. 237, 21 October 1926; L.S., 1926, Lith. 1.

LUXEMBURG²

GENERAL LEGISLATION

Act of 17 December 1925 concerning the Social Insurance Code. M., 1925, No. 63, p. 887; L.S., 1925, Lux. 2 A.

Act of 31 December 1925 to amend section 7 of the Act of 17 December 1925 concerning the Social Insurance Code. M., 1925, No. 63 p. 1005. L.S., 1925, Lux. 2 B.

Grand Ducal Decree of 6 January 1926 to fix a maximum normal wage in pursuance of the Act of 31 December 1925 concerning the normal wage to be fixed for determining the cash benefits paid by sickness funds. M., 1926, No. 1, p. 5.

Grand Ducal Decree of 26 March 1926 to regulate the electoral procedure for the election of the delegate meeting, managing committee and central committee of the sickness funds, in accordance with the Act of 17 December 1925. M., 1926, No. 11, p. 249.

Grand Ducal Decree of 26 March 1926 concerning the composition, powers and working of the Central Committee of the sickness funds. M., 1926, No. 11, p. 257.

Decree of 10 April 1926 concerning the establishment of regional funds in accordance with section 26 of the Act of 17 December 1925 on the Social Insurance Code. M., 1926, No. 13, p. 273.

Decree of 10 April 1926 to close the industrial funds which fail to satisfy the conditions laid down under the Act of 17 December 1925 concerning the Social Insurance Code. M., 1926, No. 13, p. 274.

Grand Ducal Decree of 11 June 1926 to amend section 2 of the Grand Ducal Decree of 26 March 1926 concerning the composition, powers and working of the Central Committee of the sickness funds. M., 1926, No. 22, p. 436.

Grand Ducal Decree of 27 December 1926 to fix the maximum normal wage for purposes of sickness insurance. M., 1926, No. 62, p. 92.

REPORTS

L'Assurance maladie dans le Grand Duché de Luxembourg en 1923 (Sickness Insurance in the Grand Duchy of Luxembourg in 1923). Published by the Department of Agriculture and Social Welfare. Luxembourg, 1924. Imprimerie Centrale Gustave Soupert.

¹ Abbreviation V.Z. = *Vyrausybės Žinios* (Official Gazette)

² Abbreviation M. = *Mémorial du Grand Duché de Luxembourg* (Official Gazette).

NORWAY¹

GENERAL LEGISLATION

Act of 6 August 1915 on sickness insurance. N.L., 1915, p. 633; B.B., 1916, p. 236

Act of 15 June 1917 to amend and supplement the Act of 6 August 1915 on sickness insurance. N.L., 1917, p. 350, L.S., 1920, Nor. 3 *bis*.

Act of 23 July 1918 to amend and supplement the Act of 6 August 1915 on sickness insurance and the supplementary Act of 15 June 1917. N.L., 1917, p. 489.

Provisional Act of 23 July 1918 to supplement the benefits to persons entitled to sickness benefit and family allowance in pursuance of the Sickness Insurance Act of 6 August 1915 and the Supplementary Act of 15 June 1917. L.S., 1920, Nor. 3 *bis*.

Act of 10 December 1920 to amend and supplement the Act of 6 August 1915 on sickness insurance, together with the supplementary Acts of 15 June 1917 and 23 July 1918. L.S., 1920, Nor. 3.

Act of 16 February 1923 to amend the Sickness Insurance Act of 6 August 1915 and the supplementary Acts. N.L., 1923, No. 7, p. 66; L.S., 1923, Nor. 3.

Act of 17 July 1925 to amend the Sickness Insurance Act of 6 August 1915 and the supplementary Acts. N.L., 1925, No. 33, p. 426; L.S., 1925, Nor. 4.

REPORTS

Statistisk Årbok for Kongeriket Norge (Norwegian Statistical Year Book).
Reports on Sickness Insurance

Period covered	Series	No.
1916-1918	VI,	174
1919	VII,	8
1920	VII,	32
1921	"	61
1922	"	94
1923	"	140
1924	"	180

POLAND²

GENERAL LEGISLATION

Act of 19 May 1920 on compulsory sickness insurance. D.U., 1920, No. 44, p. 272; L.S., 1920, Pol. 3.

Act of 6 July 1923 to amend sections 103, 104, and 105 of the Act of 19 May 1920 on compulsory sickness insurance. D.U., 1923, No. 75, p. 589; L.S., 1923, Pol. 3 B.

Act of 28 September 1926 to amend sections 103 and 104 of the Act of 19 May 1920. D.U., 1926, No. 101, p. 582.

Decree of the Minister of Public Health and the Minister of Labour and Social Assistance of 16 June 1921, concerning State supervision of medical assistance. D.U., 1921, No. 81, p. 561

Decree of the Ministers of Public Health and Labour and Social Assistance, dated 26 March 1923, concerning reductions of the prices given in the pharmaceutical schedule for drugs dispensed at the cost of the sickness funds. D.U., 1923, No. 61, p. 448

Decree of 30 June 1924 of the Minister of Finance, issued in agreement with the Minister of Labour and Social Assistance, respecting the conversion

¹ Abbreviation N.L. = *Norsk Lovtidende* (Norwegian Legislative Gazette).

² Abbreviation D.U. = *Dziennik Ustaw* (Bulletin of Laws).

into Polish currency (zloty) of the cash benefits mentioned in the Act of 29 May 1920 on compulsory sickness insurance. D.U., 1924, No. 58, p. 591

Decree of the Minister of Labour and Social Assistance of 9 August 1924 on the powers of the Central Social Insurance Office. D.U., 1924, No. 63, p. 619.

Order of 24 March 1926 of the Minister of Labour and Social Assistance respecting electoral procedure for sickness funds. D.U., 1926, No. 44, p. 273.

REPORTS

"Sickness Funds in 1924. Results of the Official Statistics Compiled by the Actuarial Section of the Ministry of Labour and Social Assistance" Published in Nos 3-4 of the *Social Insurance Review*, Warsaw, 1926

"Sickness Funds in 1925. Results of the Official Statistics Compiled by the Ministry of Labour and Social Assistance" Published in No 4 of the *Social Insurance Review*, Warsaw, 1927.

Social Insurance in Poland. Report Submitted by the Polish Delegation to the Seventh International Labour Conference. Warsaw, 1925

THE MINISTER OF LABOUR AND SOCIAL ASSISTANCE *Obciążenie produkcji na rzecz ubezpieczeń społecznych w polsce i zagranicą* (The Cost of Social Insurance in Poland and Abroad). Warsaw, 1926

MINISTRY OF LABOUR AND SOCIAL ASSISTANCE. *Praca i Opieka Społeczna* (Labour and Social Assistance), Quarterly Publication, Vols. I-V.

CENTRAL STATISTICAL OFFICE: *Statystyka Pracy* (Labour Statistics), Monthly Publications, Vol. I-IV.

Annual reports of the Warsaw Sickness Fund, 1920-1925.

PORTUGAL¹

GENERAL LEGISLATION

Decree No. 5636 of 10 May 1919 respecting the institution of compulsory sickness insurance. D.G., Series 1, No 98, Supplement 8, 10 May 1919 [A partial French translation is published in the *Year Book of Agricultural Legislation*, by the INTERNATIONAL INSTITUTE OF AGRICULTURE Rome, 1919, p. 669.]

Decree No. 5640 of 10 May 1919 to establish and organise the Institute of Social Insurance and Public Welfare. D.G., Series 1, No. 98, Supplement 8, 10 May 1919. [A partial French translation is published in the *Year Book of Agricultural Legislation*, by the INTERNATIONAL INSTITUTE OF AGRICULTURE, Rome, 1919, p. 691].

ROUMANIA²

GENERAL LEGISLATION

Former Kingdom and Bessarabia

Act of 25 January 1912 respecting the organisation of handicrafts, minor credit institutions and workmen's insurance. M.O., 1912, No. 226, B.B., 1913, p. 53.

Acts of 26 April and 31 May 1913 to amend and supplement the Act of 25 January 1912 on the organisation of crafts, credit and workers' insurance. M.O., 28 April and 5 June 1913.

Act of 2 July 1924 to amend and supplement provisionally certain provisions of the social insurance laws for the territory of Roumania M.O., 1924, No. 143, p. 7613, L.S., 1924, Rou. 1

¹ Abbreviation D.G. = *Diário do Governo* (Official Gazette)

² Abbreviations M.O. = *Monitorul Oficial* (Official Gazette), O.T. = *Országos Törvénytar* (National Code for former Hungary), R.G.Bl. = *Roumengesetzblatt* (for former Austria).

Ardeal

Act No. XIX of 6 April 1907 on the sickness and accident insurance of persons employed in industry and commerce. O.T., 9 April 1907; B.B., 1907, Vol. II, p. 269.

Bukovina

Act of 30 March 1888 on workers' sickness insurance. R.G.BI, No. 33, 1888.

REPORTS

Sickness Insurance Statistics, 1912-1925, published in *Buletinul Muncii*, April-May 1926, Nos. 4-5-6, pp. 205-286.

RUSSIA ¹**GENERAL LEGISLATION***Fundamental Acts*

Act of 31 October 1918 on workers' social assistance. C.L., 1918, No. 89.

Labour Code of the Russian Socialist Federative Soviet Republic, 1922 edition, chapter 17. C.L., 1922, No. 70; L.S., 1922, Russ. 1.

Civil Code of the Russian Socialist Federative Soviet Republic, section 412-415. C.L., 1922, No. 71.

Penal Code of the Russian Socialist Federative Soviet Republic, section 133.

*Regulations, Decrees, and Instructions**Scope*

Circular of 27 February 1922 on the social insurance of service men. I.N.K.T., 1922, No. 21.

Decree of 2 July 1923 to extend the Labour Code to home workers. I.N.K.T., 1925, No. 24.

Circular of 25 August 1923 on the social insurance of officials elected in rural districts. V.S., 1923, No. 35.

Circular of 7 September 1923 on the social insurance of artists on tour. V.S., 1923, No. 37.

Circular of 14 September 1923 on the social insurance of apprentices in small-scale industry and in industrial co-operative societies. V.S., 1923, No. 38.

Decree of 3 May 1924 on the conditions of employment of students on probation. V.S., 1924, No. 21.

Decree of 7 August 1924 on the social insurance of disabled persons employed in paid work. V.S., 1924, No. 33.

Decree of 16 February 1924 on the wages of persons employed in U.S.S.R. undertakings abroad. V.S., 1924, No. 21.

Circular of 23 April 1924, issuing provisional regulations on the social insurance of agricultural wage-earners. V.S., 1924, No. 17.

Decree of 18 April 1924 concerning special regulations on the employment of wage-earners in agriculture. V.S., 1925, No. 17.

Decree of 4 April 1925 on the social insurance of journalists and publicists. V.S., 1925, No. 5.

Decree of 25 September 1925 and Instructions of 31 October 1925 on the social insurance of domestic workers. V.S., 1925, Nos. 41 and 46.

Circulars on the social insurance of seasonal and temporary workers, dated 21 July, 2 August, 16 August, 8 September, 3 December 1923, 7 July, 9 July, 14 July 1924, 3 March 1927. V.S., 1923, Nos. 26, 32, 34, 37, 51, 52, 1924, Nos. 25, 27, 1927, No. 17.

¹ Abbreviations C.L. = *Collection of Laws*, V.S. = *Voprosy Strakhovaniia* (Insurance Questions), I.N.K.T. = *Izvestia Narodnogo Komissariata Truda* (Information of the People's Commissariat of Labour), D = DANILOVA, *Labour Legislation in Force*; I. = *Izvestia* (Journal published by the Central Executive Committee of the Soviet Union).

Finance

Decree of 2 January 1922, on the rate of insurance contributions. I.N.K.T., 1922, No. 8

Decree of 5 February 1922, on insurance contributions for medical attendance C.L., 1922, No. 17.

Decree of 12 April 1923, on social insurance contributions for wage-earners. V.S., 1923, No. 17

Regulations of 14 June 1923, on social insurance funds. V.S., 1923, No. 25

Instructions of 28 July 1923, on the calculation and collection of insurance contributions V.S., 1923, No. 31

Regulations of 15 January 1924, on social insurance funds. V.S., 1924, No. 8

Decree of 26 February 1925, on the rates of social insurance contributions. V.S., 1925, No. 11.

Regulations of 23 March 1926, on social insurance funds. V.S., 1926, No. 29

Decree of 14 May 1926, issuing provisional regulations on time limits for applying for allowances, and for payment I.N.K.T., 1926, No. 24-25.

Decree of 15 July 1927, on social insurance funds. V.S., 1927, No. 39.

Risks Covered and Benefits

Decree of 9 November 1920 on holidays after abortion I., 9 November 1920.

Decree of 16 November 1920, containing a list of women's occupations to be treated as manual occupations as regards for confinement. I., 16 November 1920. Supplemented by the Decrees of 4 January, 10 June, 9 September 1921 and 15 July 1924.

Decree of 18 February 1921, containing a list of the sicknesses in respect of which a holiday may be granted. I., 18 February 1921.

Decree of 11 January 1922 on the holidays to be granted to women workers in certain occupations during the menstrual periods. *Bulletin of the Central Trade Union Council*, 1923, No. 2

Instructions of 12 February 1922 on medical advisers for the insurance funds. V.S., 1923, No. 4

Decree of 8 February 1923 on supplementary allowances to the relatives of recruits V.S., 1923, No. 8

Circular of 4 February 1924 on the calculation of allowances. V.S., 1924, No. 5.

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¹ Abbreviation R.Z. = *Radnicka Zastita* (Labour Protection)

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¹ Abbreviation R.L.F. = *Recueil des Lois fédérales* (Collection of Federal Laws)

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